ASSOCIATION of MIDWIVES of NEWFOUNDLAND & LABRADOR

Newsletter No. 31, September 2004

Association of Midwives of Newfoundland and Labrador
(Chapters in Goose Bay and St. John's)
Newsletter 31
September 2004

MISSION STATEMENT

To provide professional information for midwives, and to promote the recognition of the role of midwives, and the need for appropriate legislation so that midwives in Newfoundland and Labrador are publicly funded to legally provide research-based, total midwifery care as a choice for childbearing families in this province.

This Newsletter contains a summary of the General Meeting held on September 21, 2004. The Canadian Association of Midwives meetings held in September, and the Midwifery Way Forum held in July are also summarised.

Also, included in this Newsletter is the annual list of Memorial University's recent acquisitions related to midwifery practice, and other items of interest to members.

The annual membership fees for 2005 are due on January 1. There is a membership form at the end of this Newsletter. By paying now, new members get three months free membership.

This Newsletter is the method by which members are kept informed about midwifery and other maternity matters. Send items and constructive comments to the President for forwarding to the Editor. Thank you for items contributed. Those who submit are responsible for obtaining permission to publish in our Newsletter. The Editor does not accept this responsibility.

Pearl Herbert, Editor.

AMNL General Meetings,
Tuesday, January 11, 2005, 4:00 p.m. (Island time)
and the Annual General Meeting, Tuesday, March 15, 2005 (tentative)
The meeting in St. John's will be at Telemedicine, HSC. All sites wishing to be connected need to provide their tellephone number to TETRA Telemedicine (1-877-737-0281) prior to the meeting. (For reporting problems during the meeting call 709-737-6654.)

Executive Committee
President: Karene Tweedie, CNS, 100 Forest Road, St. John's, NL, A1A 1E5
Treasurer: Pamela Browne Secretary: Kay Matthews
Past President: Ann Chaulk Newsletter Editor: Pearl Herbert
Home page: http://www.ucs.mun.ca/~pherbert/ Newsletter in HSLibrary: WQ 160 N457n

Summary of the General Meeting held on September 21, 2004, at 4:00 p.m. (Island time).

There were seven members present, and as usual there was a full Agenda for this meeting chaired by Karene Tweedie. A report was given on the progress of the making of a video (for educating about midwifery). Apparently it has been decided to have two videos, both with the

same core content, but one to also contain the history, development and present status of midwifery in Newfoundland and Labrador. Historical information is something that is often requested by people, both in and out of the province.

The idea for expanding the scope of midwifery in the Happy Valley Goose Bay area has been unable to progress because of the retirement of Cathie Murray, and Ann Chaulk and the moving of other midwives. Other news is that a midwifery supporter, Gail Turner, is now in charge of Inuit Health, and Teresa Dyson has taken Gail's former position as manager of Public Health. There have also been changes in the St. John's area with an AMNL member who was in private midwifery practice moving to Halifax, but another member has returned to St. John's and is now practicing with the assistance of two AMNL members. A member is certified as a Doula instructor by the Global Birth Initiative. The Doula scope of practice has been expanded to include auscultation of the fetal heart.

Kay reported that it is hoped that the CAM annual meeting and conference will be in New Brunswick next October. (When asked about the timing of these conferences Kay said that it had been discussed at the CAM meetings, and people prefer them in the Autumn as it is more convenient after the summer holidays when the children have returned to school. Also, the fares for travel have decreased after the peak season). Kay also emphasised how important it is to have a representative at the CAM meetings so that the AMNL can be visible and keep current with happenings in the country.

Government revisions since the AMNL General Meeting the *RSNL1990 CHAPTER M – 11 MIDWIFERY ACT* Amended: CHAPTER M-11 *AN ACT RESPECTING THE PRACTICE OF MIDWIFERY* has had the "Statutes consolidated to September 24, 2004. Regulations consolidated to September 24, 2004". http://www.gov.nf.ca/hoa/statutes/m11.htm
The White Paper, *New Proposals for Occupational Regulation*, was modified: 2004-09-27. http://www.gov.nl.ca/publicat/gsl/occreg.htm (and also appears under the nursing education government web page).

There has been a suggestion for a publicity leaflet to be developed, with assistance from Friends of Midwifery NL

Annual Report of the Canadian Association of Midwives Board Representative to the Association of Midwives of Newfoundland and Labrador submitted by Kay Matthews, AMNL representative to CAM, July 2004.

I replaced Ann Chaulk as CAM representative at the end of October 2003. Since then there have been three national conference calls, in December, April and June.

The major activities of the Board since October have been developing a Policy Manual, a Strategic Plan, planning the CAM conference in Calgary for September 2004, and a statement on Elective C-section expressing the position of CAM. These activities were developed as a result of a Board two-day retreat October 4-5, 2003 which was focussed on analysing and developing a strategic vision and team building. Some key issues which arose at the retreat included defining

midwifery such as to guide decision making and communication; the disparities between the regulated and non-regulated provinces; the need for nationally based continuing education programs (e.g. Emergency Skills, the MORE program, etc.), participation in the Primary Health Care Transition Project (PHCFT) and planning and evaluation of the annual conferences.

Since then, the Strategic Plan has been adopted and the Policy Manual updated. The agenda for the conference in Calgary has been planned and it should be an excellent conference. Participants will also have an opportunity to do some local tours and an ALARM course will be offered either immediately before or after the conference.

A small sub-committee has developed a position statement on elective C-section and this statement is available in this issue of the Newsletter.

Arising out of the Board Retreat, a Committee for the not yet regulated provinces was formed (NYRC). Some of the midwifery issues to be addressed and possible strategies/solutions will be the focus of a Forum sponsored by the Atlantic Centre for Excellence in Women's Health to be held in Halifax in July.

Canadian Association of Midwives (CAM) meeting, September 2004 submitted by Kay Matthews, AMNL rep to CAM.

The Annual Retreat of the CAM Board was held from September 13-15, 2004 in Calgary prior to the Annual General Meeting (AGM) and CAM conference. The first day was facilitated by a public relations consultant from Calgary. The objective of the day was to review the CAM strategic plan and Mission Statement which had been developed and approved over the last year and develop an operational plan to prioritize the key activities for CAM. In line with this objective, strengths and weaknesses of the organization were identified, and the activities to be carried out over 2004-2005.

The following day the consultant presented a summary of the findings of the previous day and left. These findings were discussed. A main finding was that the current administrative structure is unrealistic, as there had been a rapid growth of the organization but the structure had not grown in relation to this. There are about 450 members, but individual provinces are struggling to maintain their own associations. The present president had served her term plus a year, and nobody had volunteered to become the next president.

Lorna Breituscz (Sask.) agreed to be an interim President for six months while a new structure and responsibilities for the President and Board were worked out. Sinclair Harris (Quebec) is treasurer and Joyce England (PEI) is the Secretary. The Board gave a commitment to provide support to the President and Executive.

Under-funding and under-resourced were key weaknesses identified with the facilitator. CAM will explore hiring a fund-raiser for a six-month period to explore how we, as an association, could acquire more funds, other than through increasing membership fees. A survey will be conducted with all the members to find out their views of CAM, and how CAM can best address membership needs, etc.

Elena Johnson (ON) and Gisela Becker (Nunavut) will represent CAM when there are requests for comments from the media.

The Collaborative Maternity Care Committee (Kim Campbell represents CAM on this multi-disciplinary committee) is holding meetings on collaboration to improve maternity and address the current crisis in maternity care. Terminology and how it applies to midwifery, was questioned; such as "collaboration", "paradigm of care", "unique relationship between the woman/family and the midwife", "central to midwifery practice". Are they interpreted differently by other health professionals? Defining core values and terminology, were further discussed.

CAM will work together with the Consortium for the Regulation of Midwifery to determine how to recognize multiple routes of entry into the profession.

A commitment was made to continue to support the *Canadian Journal of Midwifery Research and Practice* (CJMRP). Discussions will be held to negotiate an increase in financial support from CAM to the journal, and a member of the CAM board will act as liaison with the CJMRP board to improve communication.

Other activities related to lobbying, better communication with members, French translation for documents and at meetings, determining the role of CAM in Emergency Skills Workshop (ESW) and developing guidelines in collaboration with the ESW consortium, ensuring aboriginal representation in attendance at and in presentations at CAM conferences.

CAM will explore holding the 2005 annual meeting in the Atlantic provinces, possibly in Moncton. The next CAM Board conference call was planned for September 30.

The Midwifery Way. A National Forum Reflecting on the State of Midwifery Regulation in Canada. July 22-23, 2004, Halifax, NS. [From Pearl Herbert's notes.]

I attended this interesting forum which was co-hosted by the Atlantic Centre of Excellence for Women's Health (ACEWH) and the Prairie Women's Health Centre of Excellence (PWHCE). There were nearly 100 participants: midwives, doulas, midwifery advocates and consumers, and government personnel (including Cathie Royle and Lorraine Burrage from NL). The majority of attendees were from the Atlantic provinces and others from Saskatchewan (SK), Northwest Territories (NT), and Nunavut (NU) where midwifery is not yet regulated. There were presentations from midwives and others from British Columbia (BC), Manitoba (MB), Ontario (ON), and Quebec (PQ) where midwifery is regulated. (I do not remember meeting anybody from Alberta (AB)).

On Thursday, a welcome was given and opening remarks were from the two Centres of Excellence and David Gass, Nova Scotia (NS) Department of Health, who is the chair of the Primary Maternity Care Working Group and Director of Primary Health Care. Dr. Gass said that in NS they are establishing mechanisms to include midwives, physicians and nurses in primary health care. Christine Saulnier (ACEWH) pointed out that it is not the value of midwifery which is questioned but how to include midwives in the health care system.

Robbie Davis-Floyd, Department of Anthropology at the University of Texas, gave the keynote address. She gave a summary of the global trends in midwifery, with examples from her field experiences, mainly in Central and South America. Modern midwifery is the medical model using science and technology. To get beyond this entails being informed and educated in the sciences, and being political in order to obtain support. Levels of midwifery education range from apprenticeship, vocational, undergraduate through to masters' degree (which we do not

have in Canada). She only seemed to be aware of the degree program in Ontario. In Brazil the obstetricians have a 75% cesarean section rate, but midwives attend all the normal births. The Netherlands has a home birth rate of 30% and the country's cesarean section rate is 9%. This contrasts with the cesarean section rates of 26% in the USA and 22% in Canada.

Later there was a book signing of *Reconceiving Midwifery* edited by I. L. Bourgeault, C. Benoit, & R. Davis-Floyd. Published by McGill-Queen's Press. (RG 950 R42 2004 in the Centre for Newfoundland Studies, MUN QEII Library).

(My impression was that Robbie Davis-Floyd did not have current knowledge of midwifery in Canada, but considered all of North America to be the same. Also, when questioned afterwards about the pressure from drug companies on the practice of medicine as a whole and obstetrics in particular, she referred to another author. She said that she had not written about this effect on the culture of childbirth in any of her books.)

In the plenary session "Canadian Midwifery Implementation: Reflections on the Last Decade," Christine Saulnier said how the regulation of midwifery provides better access to the health care system, whether in a hospital or at home. There is a shortage of physicians attending births and also consumers are requesting midwives.

Jane Kilthei of the Canadian Midwifery Regulators Consortium spoke about midwives providing continuity of care, choices of care giver and place of birth. In BC (85 registered midwives (RMs)), and ON (267 RMs) midwives are paid according to "courses of care", in MB (40 RMs) and PQ (55 RMs) by "salary", and in AB (16 RMs) privately unless working in a project when they are salaried. The provincial government pays 100% of the liability insurance for RMs in MB, ON, PQ, and subsidizes the insurance in AB. Midwives are self insured in BC.

Legislation may come into effect in the Northwest Territories in 2005 and then the word "registered" is protected but anybody may be a midwife. As there will be no College of Midwives, because of the small numbers, the NT Government has been requested to form an Advisory Group. (Alberta did not have a College when midwifery legislation was first implemented). Provincial Midwives' Colleges are now only assessing and licensing midwives who will be practicing in their jurisdictions.

In Manitoba midwives who are also nurses may practice both professions. In this province, midwives find that many employers do not understand that midwives are autonomous professionals and do not work according to the clock. Hospital privileges have been obtained but the challenge is lack of respect from hospital staff, unless the midwife has previously been known to the staff. The second attendant at a birth may be a registered nurse. Midwives have been welcomed and integrated well into community health clinics. Midwives work in Regional Health Authorities, and this has been confining when a midwife wishes to attend a previous client who lives in a different region. Midwives are required to have a case load of 50% of 'priority program mothers' and this may mean that they have to refuse other women who really want midwifery care. The MB midwifery legislation and regulations do not contain any vision for growth.

In Quebec, birthing centres are publicly funded and administered by Community Health Centres (CLSCs). Each of the birthing centres in Montreal may have seven full time equivalent midwives. Each midwife is required to be a primary midwife at 40 births, second attendant at 40 births, and back-up at 40 births. Most antenatal visits last 45 minutes. There is an assistant on

duty whenever there is anybody in the birthing centre, and she looks after the family. The midwife may leave three hours after the birth but the assistant stays. Although the mother and baby may stay for 24 hours after the birth most leave in six hours, while still feeling 'on a high'. For one birthing centre the budget is $805,100 consisting of: $536,250 for salaries, $118,500 for benefits, $129,800 for rent and basic materials, $2,500 for medications, $500 for office supplies. In PQ when clients do not have medicare they have to pay either $2,500 for the birthing centre care or $5,804 for the birth and two days in the hospital. When the cost of a birthing centre is compared to a hospital it is: $700 to $650 for hospital prenatal care, $1,310 to $2,240 for hospital intrapartum care, $280 to $130 for hospital postpartum care. The totals are $2,290 for a birthing centre and $3020 for a hospital, a saving of $730 for each mother receiving care from pregnancy through to the postpartum at a birthing centre. Although midwives may now attend births in hospitals or in the community they have been unable to do this as the midwives have full case loads for births at the birthing centres, and the government has not provided any extra money to hire additional midwives.

On Friday, Darlene Birch, a Manitoba traditional midwife, spoke about the problems where aboriginal midwives are unable to practice because the registered nurses call the RCMP to send the women south to a hospital. Dawn Walker of First Nations Inuit Health Branch, Health Canada, said that nurses do not know about birth and are afraid of being sued. Suggestions from the floor were that this is happening because nurses who are midwives are no longer being hired from other countries to work in remote areas. Also, midwifery diploma programs, such as were offered to registered nurses at the University of Alberta and Memorial University of Newfoundland, have ended. In a regular nursing education program students may not have the opportunity to observe a normal birth because of so many interventions. Darlene said that with women going to another community to give birth the mortality rates have increased and the breastfeeding rates have decreased. The mother is separated from her family and family violence has increased. Many communities only experience deaths and no births, as these occur elsewhere. Six Nations are now developing their own midwifery program.

Dawn Walker mentioned a document, *Canadian Statement on Health, United Nations Permanent Forum on Indigenous Issues May 19, 2004* which contains the following mention of midwives: "we expect to reduce overall risk while laying the groundwork for more community-based birthing in the future. Indigenous midwives are leading the drive to develop holistic services for women, babies and families that are built upon traditional practices, and promote community-based child bearing services. By reclaiming control over birth, communities can begin the process of restoring balance and harmony among their people, while at the same time ensuring health and safety for Indigenous mothers and babies and improving community wellness."

Natsiq Alainga-Kango from Iqualuit told how she sits with women in labour in the hospital. When the nurses start talking about augmenting labour, she asks them to leave the room for a while. The Inuit women are anxious to avoid intravenous infusions because this will change their lives (not explained). When the nurses have left, Natsiq explains to the woman what to do and repositions the woman to birth the baby. When the nurses return, the baby has already been born.

A plenary session on "Midwifery and Diversity: Building an Inclusive Midwifery Framework" included midwives who work with homeless women in Hamilton, and they said that 'choice' is a middle class concept. Women can have a free service from a midwife but if they have no health insurance they have to pay for hospital care. It has not been possible to 'share care' with local physicians because of the payment system.

Nadine Mondestin, from the Brown Birthing Network in Montreal reported on the history and culture of people of colour.

Jane Kilthei, chairperson of the Canadian Midwifery Regulators Consortium, said that there is a need for more midwives and a national midwifery assessment strategy is needed. BC has funding from HRCD to develop a prior learning experience assessment. ON received special funding for assessment and upgrading at Ryerson College, which has replaced the previous PLEA program. It is too expensive to audit each individual program so the required midwifery competencies are being studied with a view to making them available to those who wish to become registered midwives in Canada. Many immigrants do not have the money and language to undertake preparation for examinations. The primary competencies of a team of midwives rather than individuals could be considered. [But, this does not say what happens when the second attendant is not a midwife.] By 2010 all of Canada's labour force growth will be dependent on immigrants. [But, with the increasing number of young aboriginal people and births perhaps they will be providing the labour force.] The national competencies would be a start to obtaining a national assessment. Phase 2 - April 2005 to March 2006 is to revise and create assessment tools. Phase 3 - April 2006 to September 2006 is to evaluate research process.

On Friday afternoon the plenary session was "Examining the Barriers to Regulation in the Not-Yet-Regulated Provinces". Cathy Ellis, (MASK), and Joanne Havelock (PWHCE), opened this session and Pearl Herbert (AMNL), Joyce England (PEIMA), Kate Nicholls (MANB), and Louise Macdonald (ANSM) spoke about what were barriers in their provinces. When Pearl was questioned about midwives not being included in NL primary health care she asked Cathie Royle the Program Consultant (Prenatal and Early Child Development) Child, Youth and Family Programs, NL Department of Health and Community Services, to address the issue.

There were concurrent sessions (two on Thursday and one on Friday), on topics of interest to midwives, doulas, and consumers.

On Thursday evening there was a presentation by Ami McKay, a journalist, who gave the history of her present house, known as "The Midwife House". Ami's web site is www.amimckay.com . This was followed by the Atlantic Premiere of the film "Singing the Bones" (Some of us had attended the drama monologue, in 1995, when attending the CCM annual meeting in Winnipeg.) The food for breaks and lunches was good. The ACEWH, especially Christine Saulnier and Shelly Martin, had put much effort into organizing this forum.

Rachel Rapaport Beck of the PWHCE is gathering the notes of presenters and panelists in order to send conference proceedings to the participants.

[Congratulations to Christine Saulnier who had her baby on September 25. She laboured at home supported by her husband Michel and two midwives, Kerstin Martin and Maren Dietz. After 46 hours they went to hospital where the obstetrician broke her waters, and two hours later, at 5:00 a.m., Gabriel was born. He weighed 7 lbs 3 oz. Four hours later they returned home. His sister Madeleine loves him.]

From the Atlantic Centre of Excellence for Women's Health For Immediate Release

Improving Maternity and Newborn Care for All Women in Canada

Canadian women must have access to midwifery services irrespective of where they live or who they are.

Halifax, July 16, 2004 - Many Canadian women are still without access to regulated and funded midwifery care, even though more than a decade has passed since midwifery regulation was achieved in Ontario. In an effort to learn from the experiences of the regulated provinces and to ensure that midwifery services are made available to more women, the Atlantic Centre of Excellence for Women's Health and the Prairie Women's Health Centre of Excellence will host The Midwifery Way: A National Forum Reflecting on the State of Midwifery Regulation in Canada, on July 22 and 23, 2004, at Dalhousie University.

Midwives are not regulated in any Atlantic province, in Saskatchewan, Nunavut and in the Yukon. Regulation is pending in the Northwest Territories and pregnant women do have access to this service in British Columbia, Ontario, Quebec, Manitoba and Alberta. In Alberta, however, midwifery care is not funded under the provincial health care system. The Midwifery Way is intended to harness the renewed energy that has been generated around midwifery, evident in the recent decision by the Nova Scotia Department of Health to establish the Primary Maternity Care Working Group, which will find ways to incorporate midwifery into Nova Scotia's primary maternity care system.

"The evidence is in, it is time to stop debating the value of midwifery for pregnant women and their children and indeed their family and communities. Midwives are the only care-givers that focus on birth as a healthy physiological process" says Dr. Christine Saulnier, Senior Research Officer at the Atlantic Centre of Excellence for Women's Health. "It is my hope that this forum will lead to many other events to help strengthen the midwifery movement and moreover to develop strategies to improve maternity and newborn care in Canada."

At a time when Canadian women are facing a maternity care crisis, it is vital that these primary care providers are integrated into the Canadian health care system from coast to coast. "Midwives are the only maternity care provider group whose numbers are growing rather than declining." At the same time, Gisela Becker, Registered Midwife and President of the Midwives Association of the Northwest Territories and Nunavut pointed out, "It is also vital that midwives engage in collaborative partnerships with other health professionals, while maintaining their distinct autonomous practice model."

There are, however, many obstacles in the way of building a truly inclusive model of midwifery practice - one where services are provided by and to women who have been under-represented or under serviced by the health care system. This forum promises to be a dynamic and engaging event that brings together scholars, activists, consumers, other health care practitioners and representatives from various government departments to address these and many other issues.

For more information or to arrange an interview, please contact:
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Canadian Association of Midwives
Position statement on elective cesarean section
June 2004

The Canadian Association of Midwives (CAM) allies with the society of Obstetricians and Gynecologists of Canada (SOGC) by stating that vaginal birth is clearly the safest birth for most women and babies, and that caesarean surgery on demand will have disastrous social and financial consequences for health internationally. CAM advocates safe, sensitive care within a health system that maximizes women's ability to have a normal physiologic labour and birth.

We agree with the position taken by Canadian and international midwifery and citizen organizations, that resources are needed to support continuity of care, one to one care in labour and increased access to midwifery services. The debate around c-section on demand raises deep concerns for midwives about the persistent increase in obstetrical interventions and surveillance technologies used for pregnancy and birth. In many cases the increase is occurring without regard for substantiating data and despite efforts by professional organizations and consumer groups to curb rates of intervention which are not supported by evidence. This trend both reflects and serves to construct a mechanical and fragmented vision of the body and birth and also of the pregnant woman and her unborn baby. It is a product of our society's "culture of fear" around childbirth and demonstrates the extent to which the "epidemic of risk" is reflected in maternity care.

Presenting interventions such as c-section as "options" puts maternity care providers and women in a consumerist relationship, and treats childbirth as a problem to be solved rather than a process to be respected. The importance of the social and cultural aspects of birth is supported by a broad humanistic discourse in the scholarly and public literature. Moreover, strong scientific evidence supports a low intervention approach. Vaginal birth is not "an option". It is a complex, highly developed physiologic process that deserves our fundamental respect. It is the role of midwifery and medicine to understand, promote, and facilitate physiologic processes, and to intervene only when necessary.

The benefits of caesarean section and certain obstetrical interventions for specific problem situations are irrefutable. However, widespread use of intervention and technology creates fear and doubt about the adequacy of the female body, and reinforces distrust about the reproductive powers of women. When women request interventions that are not medically indicated, and when professionals offer unnecessary technology rather than support and reassurance, it may simply be an expression of those doubts. These requests can also be seen as a reflection of a system greatly in need of improving its ability to provide sensitive, supportive care in childbirth. The research on caesarean section by request clearly shows that anxiety and fear play a major role and that these factors can be addressed by more effective means than by surgery.

Offering all women the choice of caesarean section is not safe and not ethical.

Midwives work in a model of care that supports the development of relationship. The potential for empowerment through "informed choice" is much more than a neutral offer of choice. Midwifery care involves mutual trust, dialogue and acknowledgement of the fundamental uncertainty and complexity of pregnancy and birth. In that sense, empowerment comes through a process of shared decision making, not through a "menu" of choices.

For women, families, midwives and for many other maternity care providers, childbirth is a deeply meaningful event. As a multidimensional life experience, its significance and symbolism touch the core of every society and every culture. Embedded in a historical and socio-cultural context, childbirth is far more than a medical event. As professionals, midwives consider the individual woman within her life context, and take into account factors that affect her overall health. Health policy must also take into account the societal implications affecting health as a common good. To build maternity care that is truly women centered will require beginning with the fundamentals: trusting women and supporting their ability to trust themselves, their bodies and the birth process.

http://members.rogers.com/canadianmidwives

(Reviewed in *ICM International Midwifery, 17*(4), 43.)

More Than 1 in 5 Canadian Babies Now Delivered by C-Section. Fewer family doctors delivering babies

(April 21, 2004) —Canada's caesarean section rate reached an all-time high of 22.5% of in-hospital deliveries in 2001–2002, according to a new report by the **Canadian Institute for Health Information (CIHI).** This trend coincides with a decline in the number of family doctors providing full maternity care. Fewer than 19% of family physicians billed for obstetrical services in 1999—compared with just over 31% in 1989.

Giving Birth in Canada: Providers of Maternity and Infant Care, the first document of a four-part series on giving birth in Canada to be published this year, shows that while most family physicians still provide some maternity care, fewer are delivering babies than in the past. In addition, they are less likely to deliver multiple births or perform caesarean sections. In 2000, obstetricians attended 61% of vaginal births and 95% of all caesarean births—up from 56% and 93% in 1996, respectively. Of those obstetricians who attended births, the majority (64%) attended between 101 and 300 in 1999. Family physicians who attended births attended 41 on average in 2000. The proportion of family physicians attending deliveries ranged from 8% to 69%, depending on the province or territory. Family physicians in the western provinces and the territories are more likely to deliver babies than those in central or Atlantic Canada, and small town/rural area family doctors are more likely to attend deliveries than their urban counterparts: 27% reported delivering babies in 2001, compared with 12% in urban areas.

"Family doctors entering practice may believe that maternity care will add more stress to their already busy lives," explains Dr. Elizabeth Whynot, President of the British Columbia Women's Hospital and Health Centre. "Research on new family doctors suggests that confidence in obstetrical skills, fee structures, and fear of malpractice suits are all factors that inhibit them from choosing to deliver babies as part of their practice."

The report also shows that while 34% of obstetricians/gynaecologists were planning to retire between 1999 and 2004, about 250 are projected to have entered residency programs in this field over the same time period. In 2002, Ontario had the highest rate of obstetricians/gynaecologists, with six per 100,000. Newfoundland and Labrador, Prince Edward Island, New Brunswick, Saskatchewan and Alberta all had the lowest, with four per 100,000. This report raises questions about who will be supporting mothers and delivering their babies in the future," says Dr. Whynot. "By understanding the evolving trends, health planners may be better equipped to find new ways to broaden support for a full spectrum of maternity care—from obstetricians and family doctors to midwives, nurses and nurse practitioners."

More Report Findings

- Canada's overall birth rate dropped from 14.5 per 1,000 in 1990–1991 to 10.5 per 1,000 in 2000–2001.
- Canadian mothers are getting older. In 1991, 34% of babies in Canada (excluding Ontario) were born to women aged 30 and over. By 2000, the number of mothers over 30 years of age had increased to 42%.
- Care during childbirth varies in urban and rural areas. In rural areas, there is less capability for caesareans and there are fewer anaesthesia services available than in the cities. The mix of care providers also differs. Rural family doctors are more likely to attend births, while there are fewer specialists, obstetricians, and anaesthesiologists per capita in rural areas than in cities.
- Birth rates in the far North are among the highest in the country. Women in the far North with complications, or those requiring a caesarean birth, still often travel south to a hospital; but new options, such as birthing centres, are now available in some northern communities. In northern Ontario, however, fewer community hospitals are offering obstetrical services: 36 of 39 communities did so in 1981, compared with 24 in 1999, according to research by Peter Hutten-Czapski of the University of Ottawa.
- An increasing number of expecting mothers (3% nationwide in 2000–2001) reported receiving prenatal care from midwives. The number of jurisdictions regulating and funding midwives in Canada is increasing—and so is the number of trained midwives. Their participation in births is also rising. Ontario, for example, saw nearly a seven-fold increase between 1994–1995 and 2000–2001 in hospital births attended by midwives.

Canadian Institute for Health Information (CIHI)

The Canadian Institute for Health Information (CIHI) is an independent, pan-Canadian, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality health information. CIHI's mandate, as established by Canada's health ministers, is to coordinate the development and maintenance of a common approach to health information for Canada. To this end, CIHI is responsible for providing accurate and timely information that is needed to establish sound health policies, manage the Canadian health system effectively and create public awareness of factors affecting good heath.

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Canadian Perinatal Surveillance System (CPSS)

The CPSS has published a *Special Report on Maternal Mortality and Severe Morbidity in Canada - Enhanced Surveillance: The Path to Prevention.* While Canada has lower mortality ratios (MMRs) than either the United States (US) or the United Kingdom (UK), there are still countries with better ratios (calculated by maternal deaths per 100,000 live births). Interventions to improve the Canadian rate were investigated.

The *Confidential Enquiry into Maternal Deaths in the United Kingdom* was initiated in England and Wales in 1952 and now covers all of the UK. There is a government requirement that all maternal deaths are subject to confidential enquiry. This enquiry and report are viewed as the "gold standard" for maternal mortality surveillance. The *Report on Maternal Deaths in Australia* was initiated in 1964. The report is the product of various state and territorial Death Enquiries, and morbidity and mortality databases, so the data are variable in both detail and quality. The US *Pregnancy Mortality Surveillance System* was initiated in 1987, but it does not conduct individual reviews of the medical circumstances surrounding death and no individual case-level detail is provided. At the Canadian national level there is currently no systematic mechanism in place to synthesize and report on maternal deaths in Canada.

The CPSS was developed by Health Canada in 1995 (and midwives (CCM/CAM) have been represented on the CPSS from it's initiation). The CPSS mandate is to contribute to improved health for pregnant women, mothers and infants in Canada through ongoing monitoring and reporting on perinatal health determinants and outcomes. One of the CPSS three study groups, the Maternal Health Study Group, with the support of the Society of Obstetricians and Gynaecologists of Canada (SOGC) initiated this special report on maternal mortality and severe maternal morbidity in Canada.

A list of deaths during 1997 to 2000 was obtained from Statistics Canada's Canadian Vital Statistics System, from the Discharge Abstract Database (DAD) of the Canadian Institute for Health Information (CIHI), and from the hospital separations in the province of Quebec. As hospital separations from Quebec, parts of Manitoba, and Nova Scotia were not included in the DAD, these provinces are not included in the severe maternal morbidity analysis. However, DAD does not always identify true maternal deaths.

Definitions of maternal deaths

Maternal deaths: deaths of women while pregnant or within 42 days of the termination of the pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

> Direct obstetric deaths: maternal deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium); interventions, omissions or incorrect treatment; or a chain of events resulting from any of the above (ICD-9 and ICD-10).
>
> Indirect obstetric deaths: maternal deaths resulting from previous existing disease or disease that developed during pregnancy, which was not due to direct obstetric cause but which was aggravated by the physiologic effects of pregnancy (ICD-9 and ICD-10).

Incidental deaths: deaths due to conditions occurring during pregnancy, where the pregnancy is unlikely to have contributed significantly to the death, although it is possible to postulate a distant association (previously referred to as fortuitous deaths).

Late maternal deaths: deaths of women from direct or indirect obstetric causes occurring between 42 days and one year after termination of pregnancy (new ICD-10 category) (p. 6).

Only Manitoba, Saskatchewan, Alberta and Northwest Territories have established committees with a mandate to investigate all maternal deaths in their jurisdiction. Only six of thirteen provincial and territorial Coroner's Acts specifically mention pregnancy. In British Columbia notification of a death does not translate into formal investigation for all maternal deaths. Quebec does not have a maternal death review committee and the coroner is not routinely notified of all maternal deaths. The provinces and territories vary in defining which pregnancy-related deaths will be investigated, as well as the specific details collected for each maternal death, even when review committees exist. From the findings very little information is disseminated or shared across jurisdictions.

This report found that the five leading causes of direct maternal deaths were: pulmonary embolism, pre-eclampsia/pregnancy-induced hypertension, amniotic fluid embolism (AFE), intra-cranial haemorrhage, and ectopic pregnancy. In the future the distribution between direct and incidental deaths will change because of some of the changes in maternal death classification guidelines between ICD-9 and ICD-10. Also there is a higher MMR observed when the maternal age is over 20 years, and also with the use of operative procedures, both of which are currently increasing.

Recommendations include: establishing committees and ensuring that all maternal deaths are reported and investigated, and the consistency in the definition of maternal death, and timely feedback to the local health care providers, and national reporting

The **Appendixes** include a sample of a Maternal Death Data Collection Tool, and the relevant International Classification of Diseases, Ninth Revision (ICD-9) Codes.

Recommendations

1. Where feasible, specific maternal death review committees should be established (or maintained) as the ideal maternal death review mechanism. [The size of the population may necessitate a regional-level review mechanism.]
2. In jurisdictions without a specific maternal death review committee, the coroner/medical examiner should be a focal point for maternal death review activities.
3. Whether in the form of a specific maternal death review committee or in collaboration with the coroner/medical examiner, an appropriate body should be authorized to review reports of maternal death and seek additional, pertinent case information as necessary.
4. Legislation on notification to coroners/medical examiners in all jurisdictions should specifically mention "pregnancy" to ensure complete ascertainment of maternal deaths.
5. Coroner/medical examiner reports on deaths during pregnancy or following pregnancy should be collated so that they are easily retrievable for maternal death review activities.
6. Consistency in the definition of maternal death and in the information collected on each maternal death should be attained across all jurisdictions, including attention to vulnerable populations.
7. An ongoing mechanism should be established for national synthesis and reporting of provincial/territorial maternal death investigations.
8. Maternal death review activities at the provincial/territorial, regional and national level must ensure timely feedback to health care providers and facilities active in maternity care.
9. Future efforts should refine the coding and classification system for severe maternal morbidity in Canada's hospitalization databases, with particular attention to the change from ICD-9 to ICD-10.
10. Future reports should explore the use of indicators that combine severe maternal morbidity and maternal mortality, for example, the ratio of maternal deaths to "near miss".
11. Consideration should be given to reviewing individual cases of specific types of severe maternal morbidity, where feasible. (p. 25)

Health Canada. (2004). *Special Report on Maternal Mortality and Severe Morbidity in Canada - Enhanced Surveillance: The Path to Prevention.* (Cat. No. H39-4/44-2004E). Ottawa: Minister of Public Works & Government Services Canada.
May be accessed electronically by http://www.hc-sc.gc.ca/pphb-dgspsp/rhs-ssg/index.html
Also on this web site is a new CPSS Fact Sheet: *Physical Abuse During Pregnancy* (2004).

ITK welcomes PM's $700 million prescription, *Nunatsiaq News*, No. 33, September 17, 2004.
http://www.nunatsiaq.com/news/nunavut/40917_01.html
[On September 13] Newfoundland Premier Danny Williams told first ministers about a recent trip that he made to the Inuit and Innu communities of northern Labrador, praising the overworked nurses who provided health care in that region. In a brief speech, Nunavut Premier Paul Okalik repeated what he's said many times before at similar gatherings, reminding first ministers that 85 per cent of Nunavut's population are aboriginal people. Okalik said Nunavut's issues include the training of Inuit to work in health professions and the need to develop midwifery programs. (p.19)

Have You Read?

The *British Medical Journal* (BMJ) now publishes two versions of papers. The abridged version is published in the paper journal. The full version is available as an electronic paper which may be accessed via the *BMJ* web site: http://bmj.bmjjournals.com/ and click on articles shown in the menu on the left side of the home page.

Midwifery and Related Topics

- Barker, D. (2004). The midwife, the coincidence and the hypothesis. *MIDIRS Midwifery Digest, 14*(2), 182-184. [From December 2003, *BMJ, 327*(7429), 1428-1430. Around 1903 the medical officer of health for Hertfordshire stated: "Hertfordshire does less than forty out of the fifty-five counties to perpetuate the national stock; for England and Wales the birth-rate has for thirty-three years been steadily declining. . . . It is of national importance that the life of every infant be vigorously conserved". Ethel Margaret Burnside, the county's first chief health visitor and lady inspector of midwives responded to this challenge. In 1911, she set up an army of trained nurses to attend women in childbirth and to advise mothers on how to keep their infants healthy after birth. A health visitor (public health nurse) went to each baby's home at intervals and recorded its illnesses and development on a card. When the baby reached 1 year old the information from the card was transcribed into ledgers. A separate ledger for each village. In 1974 the position of medical officer of health was abolished and many of the records were destroyed. Others were sent to County Hall and researchers at Southampton University were able to obtain permission to remove these ledgers to the University archives. They traced 15,000 men and women born before 1930, and 3,000 had died. Almost half had died from coronary heart disease or related disorders. A disproportionate number had been of low birth weight. The risk of a fatal heart attack was halved for those who weighed 10 pounds or more at birth. Men who put on weight slowly and weighed 18 pounds or less at 1 year of age were three times more likely to die of coronary heart disease than those who weighed 27 pounds or more. Findings using these old records has resulted in the fetal origins hypothesis, which proposes that cardiovascular disease originates through the responses of fetus or infant to under-nutrition that permanently changes the structure and function of the body.]
- Clinical Issues. (2004). Promoting positive birth experiences. *JOGNN, 33*(4), 484-518. [There are three articles in addition to the introduction . Storytelling is an old means of integrating transformative moments in the human experience. (The Midwifery Way forum, heard this from Ami McKay of Nova Scotia http://www.amimckay.com).]
- Duff, E. (2004). A worldwide look at what is happening in midwifery. Brian Lara drinks cup of tea (and by the way over 400 midwives meet in Trinidad. *MIDIRS Midwifery Digest, 14*(2), 178-180. [The ICM held its Americas Regional Conference in Port of Spain, Trinidad. Over 50 nationalities were counted at the opening ceremony. The opening keynote message was entitled "Facilitating dialogue between traditional and professional midwives". Many speakers reviewed the past, examined the present critically, and expressed hopes and ambitions for the future. The huge differences between the various parts of the Americas became far clearer when the history of the distinct areas was outlined.]

- Decision time limit to be extended by NMC.(2004). *RCM Midwives Journal, 7*(7), 281. [The Nursing Midwifery Council is extending the time limit for decisions on applications from overseas midwives and nurses wishing to work in the UK from one to three months. The three-month time limit it ins line with present EU legislation. A new guide for non-EU applicants will be published shortly. See: www.nmc-uk.org/overseasreg .]
- Fielder, A., Kirkham, M., Baker, K., & Sherridan, A. (2004). Trapped by thinking in opposites? *ARM Midwifery Matters,* No. 102, pp. 6-9. [Can midwives move ahead if we think in a dualistic fashion; to do - to think? For other interesting articles see: www.radmid.demon.co.uk/index.htm]
- Goebel, N. (2004). High dependency midwifery care: Does it make a difference? *MIDIRS Midwifery Digest, 14*(2), 221-226. [This article considers midwifery care in a tertiary high dependency unit as opposed to full intensive care (a tertiary care unit?) and illustrates the situations with three case studies. To provide standardization of the care communication needs to be both verbal and with adequate written documentation which follow an agreed care plan. The woman's anxiety levels increase with all the intervention and technology, and she needs to feel that the midwife's skills are adequate to provide the necessary care. Appropriate explanation and information can ease the anxiety and facilitate a more positive experience. The woman's family doctor should be aware of her admission history. An Irish study on the use of a high dependency unit in an obstetric setting did not obtain input from midwives. The role of the high dependency midwife in relation to bonding and the promotion of the new family unit is unique but can be difficult. Further research is needed, to include the views of midwives and of the mothers. Midwives need to be asked what specialized preparation they need to work in a high dependency unit.]
- ICM Asia Pacific Regional Conference revitalising midwifery: Refocus, redefine, rebirth. *ICM International Midwifery Journal, 17*(3), 32-33. [A report on the conference held in November in Hong Kong.]
- Jones, A., Henwood, F., & Hart, A. (2004). Research into EPRs: How midwives really feel. *RCM Midwives Journal, 7*(8), 336-339. [The intention is that Electronic patient records (EPRs) will reduce the amount of time. It will save time printing forms, and when carrying out research and compiling statistics. Most midwives apply a 'resistive compliance' to computer data-entry workload. When asked it was found that they are not very interested in the development of EPRs. Nor do they know much about such developments. They saw it as necessary for the service, appropriate to midwifery needs, something they must do, and have become accustomed to it. Midwives could see the clinical value of having the system, but they should be questioning the value of the present system. They should be asking questions as it is their responsibility to find if it really is the best use of their time to enter data onto EPR systems when they have already written it in a paper record, and how does it benefit mothers.]
- Midwives in the Americas Region achieve communication, collaboration and celebration. *ICM International Midwifery Journal, 17*(3), 28-29. [A report on the conference held in April in Trinidad.]
- Nursing leadership convenes to help nurses, patients quite smoking. (2004). *AWHONN Lifelines, 8*(3), 257-259. [In the USA approximately 16% of nurses smoke, a figure less than the national average of 25% but far in excess of the 3% smoking rate among physicians. There is a website www.tobaccofreenurses.org .]

- RCM Annual Conference. (2004). Motions. *RCM Midwives Journal, 7*(7), 299. [The first motion was for the RCM to establish standards for midwives acting as expert witnesses and to establish a register of individuals so qualified. RCM to immediately convene a training programme for suitably-qualified individuals to standardise quality and relevance of experience. The motion was carried.]
- Watts, N. (2004). Screening for domestic violence. A team approach for maternal/newborn nurses. *AWHONN Lifelines, 8*(3), 210-219.

Pregnancy

- Albrecht, S. A. (2004). Achieving SUCCESS. Nursing care for pregnant women who smoke. *AWHONN Lifelines, 8*(3), 190-191. [When a pregnant woman smokes there are consequences to both the mother and the baby. The risk for low birth weight is doubled, and there is also an increased risk for placental dysfunction (including previa or abruption), prematurity and possible perinatal loss. Fifteen to 29% of pregnant women smoke. Babies of parents who smoke are more likely to suffer from respiratory and ear conditions, reduced lung capacity, behavioral and learning disabilities, and conduct disorders, and have twice the risk of dying from sudden infant death syndrome. There are specific goals for Setting Universal Cessation Counseling, Education, and Screening Standards (SUCCESS). The 5- to 15-minute intervention includes the "5 A's": Ask, Advise, Assess, Assist, Arrange.]
- Armour, K. (2004). Antepartum maternal-fetal assessment. Using surveillance to improve maternal and fetal outcomes. *AWHONN Lifelines, 8*(3), 232-240.
- Broers, T., King, W. D., Arbuckle, T. E., & Shiliang, L. (2004). The occurrence of abruptio placentae in Canada: 1990 to 1997. *Chronic Diseases in Canada, 25*(2), 16-20. [Little information on the occurrence of abruptio-placentae in Canada. It was found that the rate was increasing and was highest in mothers over 40 years of age. The case-fatality rate was highest in those under 20. Available from: http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/cdic-mcc/index.html]
- Devries, K. M., & Greaves, L. J. (2004). Smoking cessation for pregnant women. Current Canadian programs and future development. *Canadian Journal of Public Health, 95*(4), 278-280. [Only nine programs were specifically designed for pregnant and/or postpartum women, and of these four provided evaluation data.]
- Grieve, S. (2004, Spring). The pregnant traveller: Advice for women 'of a certain age'. *RCN Midwifery Connections*, pp. 2-3. [Fully comprehensive insurance that includes the unborn baby and/or premature delivery and neonatal care is essential. Failure to inform insurers of a pregnancy can be costly if an emergency occurs. Pregnant travellers should carry a copy of their medical records and test results, and also leave a duplicate record with a reliable source at home. During early pregnancy, nausea/vomiting is likely to be aggravated by travel. Some destinations are more hazardous than others. Lack of road safety and vehicle maintenance, and poor driving habits can result in blunt trauma causing maternal and fetal morbidity and mortality in pregnant women. Activities such as water skiing or scuba-diving are best avoided. Thrombo-embolism is a risk when travelling by air, or long journeys by road, because in pregnancy there is a change in clotting factors and pressure of the expanding uterus. The risk of AIDS and hepatitis B from unscreened blood transfusions is high in poorer countries. Surgery, sterility and drug therapy may be

non-existent. Pre-arranged screened blood can be delivered within 24 hours, but travel practicalities may not make this possible. Live virus vaccines should be avoided, if possible. A letter of exemption for yellow fever may be needed to enable entry to a country. Malaria tends to be more severe in pregnant women with an increased likelihood of abortion, stillbirth and premature birth. The WHO advises pregnant women not to travel to areas of chloroquine resistance. Chloroquine and proguanil are considered safe in pregnancy but as proguanil is an antifolate, folic acid should be taken. Prior advice should be requested on health requirements at the intended destination. Also see: http://www.hc-sc.gc.ca/pphb-dgspsp/tmp-pmv/index.html]

- Pre-term procedure called into question. (2004). *RCM Midwives Journal, 7*(7), 279. [Cervical cerclage to keep the cervix closed to prevent preterm birth, has been widely used for 50 years. A UK study at King's College Hospital, used ultrasound screening to identify women with a short cervix (assumed to be at a higher risk of premature birth).These women were randomly assigned to receive either cervical cerclage (250 women) or no surgery (250 women). Only a small decrease in the proportion of premature births, defined as delivery at or before 33 weeks pregnancy, occurred among women given cervical cerclage.]
- Ruiz, R. J., Fullerton, J., & Brown, C. E. L. (2004). The utility of fFN for the prediction of preterm birth in twin gestations. *JOGNN, 33*(4), 446-454. [Fetal fibronectin (fFN), is a protein adhering to the decidua, the chorion and the placenta. It can be detected in cervico-vaginal secretions from the posterior fornix, during the time of implantation and then prior to labour. fFN can be a predictor of preterm birth when detected at 22 to 24 weeks gestation. A cervix shorter than 25 mm has also been identified as a predictor of preterm birth. Studies are needed using fFN as a biomarker, particularly with monochorionic and with dichorionic twins.]
- Thomas, S. (2004, Spring). Epilepsy and pregnancy: Women matter. *RCN Midwifery Connections*, pp. 6-7. [The RCN supports the UK campaign by Epilepsy Action, Women Matter, http://www.epilepsy.org.uk/info/pregnancy1.html which discusses why a pregnancy should be planned, the need to keep well, to take folic acid, birth defects, seizures, and breastfeeding.]
- Tinsley, V. (2004, Spring). New antenatal care guidelines: Is less really more? *RCN Midwifery Connections*, pp. 3-5. [The guideline, developed by the National Collaborating Centre for Women's and Children' Health (NCCWCH) for the National Institute for Clinical Excellence (NICE), recommends the first changes to antenatal care since the 1920s. These guidelines include that women with uncomplicated pregnancies should receive fewer antenatal appointments, 10 for first-time mothers and seven for multigravida mothers, as long as everything is normal (which is a decrease from the average of 14 visits). Appointments to start at an earlier stage in pregnancy, and an early ultrasound scan instead of using the date of her last menstrual period. Women should be offered screening for Down's Syndrome and other tests such as at: 11to14 weeks - nuchal translucency, hCG, and PAPP-A; 14-20 weeks - hCG, AFP, uE3, inhibin A; 11 to 14 weeks and 14 to 20 weeks - NT, PAPP-A, hCG, AFP, uE3, inhibin A. Evidence does not support routine screening for gestational diabetes mellitus and therefore it should not be offered. Fetal presentation should only be assessed at 36 weeks or later, and routine fetal movement recording should be abandoned. Routine auscultation of the fetal heart is no

longer recommended, but an exception can be made when it is requested by the woman. These guidelines have been based on grade A recommendations from systematic review and meta-analysis of randomized controlled trials. Qualitative evidence which provides socio-emotional and psychological information is not considered. The guideline is very clinical in its content, concentrating on medical interventions and not on the mother and her family into which the baby is going to be born.]

- Wang, S-M. (2004). Backaches related to pregnancy: The risk factors, etiologies, treatment and controversial issues. *MIDIRS Midwifery Digest, 14*(2), 197-201. [From 2003 issue of *Current Opinion in Anaesthesiology, 16*(3), 269-273. In multiple retrospective studies from the late 1970s to the early 1990s epidural analgesia had a high correlation rate with back ache. The degree of motor blockade and the type of local anesthetic and the types of additive injected into the epidural space seem to be important in the genesis of back pain. More recently there have been changes in epidural analgesia. The use of ambulatory labour epidural analgesia, avoiding motor blockade, is associated with a trend towards less backache than a similar epidural regimen in patients confined to bed. Pregnancy-related backache is not a simple problem, but may be preventable in some cases. The article has references and recommended readings marked as being of outstanding interest.]

<u>Genetics</u>

- Kirwan, D. (2003, Autumn). What is Keleinfelter Syndrome? *RCN Midwifery Connections*, pp. 2-3. [Kleinfelter Syndrome (KS) is caused by an extra 'X' chromosome, so that the affected male is XXY. Some men have medical problems, and some are only diagnosed when attending an infertility clinic. Most marry and have normal sex lives, but are infertile. On average, KS men tend to be taller. The level of intelligence varies. Past information was obtained from men retained in mental institutions and prisons, which has resulted in a stereotype of KS. A UK study found that midwives and obstetricians were not always up-to-date with their information.]

<u>Labour and Birth</u>

- Baker, P. N., & Hayman, R. (2004). To pull or not to pull? Instrumental vaginal delivery. *MIDIRS Midwifery Digest, 14*(2), 212-218. [From the Spring 2004 issue of the *Journal of the Association of Chartered Physiotherapists in Women's Health,* No. 94, 11-18. Fetal indications for assisted vaginal delivery are: Malposition, which occurs more frequently with regional anaesthesia as a consequence of alterations in the tone of the pelvic floor that impedes spontaneous rotation to the optimal occipito-anterior position. Presumed fetal compromise. Ventouse extraction should be avoided when there is less than 35 completed weeks of gestation because of the risk of cephalohaematoma and intra-cranial haemorrhage, or when there is a face or breech presentation, or when the position of the fetal head is unknown, or if there is a significant degree of caput. The operator needs to be experienced. When compared with forceps, for every 20 vacuum deliveries there is one extra failure. For the baby, vacuum extraction is likely to be associated with low APGAR scores and the need for phototherapy. Babies born by cesarean section have less trauma than those born by forceps but are more likely to require admission for intensive care. Maternal indications for assisted delivery are: Distress, exhaustion or undue

prolongation of the second stage of labour (but increase this time by an hour if the mother is receiving epidural analgesia), and medically significant conditions such as aortic valve disease. A cesarean section should be considered if there is an expected failure of forceps or ventouse extraction. The psychological consequences of transferring a mother to the OR in the second stage should not be underestimated, and often results in significant morbidity and mortality. Women who have vacuum extraction may have an increase in bowel urgency, but fewer injuries than those occurring with the use of forceps. A cesarean section is more likely when the woman's BMI is greater than 30, or baby's birth weight greater than 4.0 kg, or in an occipito-posterior position. The pelvis should be examined as instrumental deliveries are difficult if the pelvis is anthropoid (narrow), android (male/funnel-shaped) or platypelloid (squashed). Postpartum haemorrhage is commoner in women needing instrumental vaginal delivery compared to women who deliver spontaneously, but less common than in women delivered by cesarean section in the second stage of labour. If the fetal head has descended far into the pelvis it may make a cesarean section hazardous. The advice to opt for a cesarean section instead of rotating the head with Kiellands forceps is based on little evidence, just the views from one study.]

- Buckley, S. J. (2004). Undisturbed birth: Nature's hormonal blueprint for safety, ease and ecstasy. Part 1. *MIDIRS Midwifery Digest, 14*(2), 203-209. [A previous version of this paper was in the 2003 issue of *Journal of Prenatal and Perinatal Psychology and Health, 17*(4), 261-288. The role of a good midwife is the guardian of normal birth. Undisturbed birth does not mean being unsupported, or without pain, or an easy birth. The primary hormones are oxytocin (hormone of love), beta-endorphin (transcendence), the catecholamines (excitement), prolactin (tender mothering). Their level increases during labour and peaks around the time of birth, and then subsides. The sex steroids progesterone and estrogen are the major hormones involved in activating, inhibiting, and reorganising other hormone systems in pregnancy, labour and birth. The newborn's oxytocin levels peak at around 30 minutes after birth. During the first hour both mother and her baby are bathed in an ecstatic cocktail of hormones, including oxytocin, the hormone of love. The olfactory sense (smell) augments oxytocin release and is thought to be important in the establishment of mothering behaviour. One study found that monkeys delivered by caesarean section rejected their babies unless they were swabbed with secretions from the mother's vagina. Oxytocin keeps the mother relaxed and well nourished. Mothers who breastfed for more than seven weeks were calmer when their babies were six months old than mothers who did not breastfeed at all. Beta-endorphin is a naturally occurring opiate, and peaks in the mother's blood stream 20 minutes after she begins breastfeeding, and is present in breastmilk, inducing a pleasurable mutual dependency for mother and baby. Adrenline and noradrenaline (catecholamine hormones) increase just before the birth of the baby. The catecholamine rush and the oxytocin hormone will produce very strong contractions so that she births her baby quickly. The baby also experiences a marked surge of catecholamines, which helps the newborn metabolism by increasing levels of glucose and free fatty acid, which protect the brain from the low blood sugar that naturally occurs in the early newborn period. Although prolactin levels rise progressively during pregnancy, its actions on the breast are inhibited by progesterone, until the placenta is delivered. Prolactin effects cause a mother to be vigilant and helps her to put her baby's needs first. Many references are given for this article.]

- Odent, M. (2004). Are caesareans the future? *RCM Midwives Journal, 7*(7), 276. [We need to think long term, and a tool for this is the Primal Health Research databank. This database is specialised in studies that explore the long-term effects of what is happening at the beginning of our life. We can draw conclusions from the accumulated data. A woman can give birth more easily if her midwife has a low level of adrenaline. Repetitive tasks, such as knitting, reduce tension. In a well-equipped and well-organised hospital the modern cesarean section is a safe operation, but the question is: can humanity survive the safe cesarean section?]
- Sosa, G. (2004). The African well women clinic at the Whittington Hospital NHS Trust. *MIDIRS Midwifery Digest, 14*(2), 255-260. [It is estimated that 130 million girls and women throughout the world have received female genital mutilation (FGM). FGM is practised in 28 African countries, South Asia and the Middle East. FGM is not mentioned in the Quran, the Torah, or the Bible. There are three (or four) main types of FGM. When obtaining a health history women from these countries should be asked if they have received FGM. They should be examined because often they do not know which kind of FGM they have received. De-infibulation can be carried out during pregnancy at any time after 20 weeks gestation. Early de-infibulation assists in the diagnosis and management of complications such as urinary tract infections, recurrent vaginal infections and miscarriage, and provides access for vaginal examination and to the urethra if catheterisation is required. Many women prefer to wait until they are in labour, so that they can experience both painful things at the same time. It is better to perform the de-infibulation during the first stage of labour. A bilateral episiotomy must not be performed. De-infibulation can be performed under local, spinal or general anaesthetic, and lignocaine gel 2% is prescribed as the exposed tissue is extremely sensitive. Correct suturing, with Vicryl Rapide 3/0 sutures, around the exposed area is needed to prevent 'raw' edges and partial re-infibulation. Re-infibulation has been illegal in the UK since the introduction of the Female Circumcision Act 1985 and the Children's Act 1989 offers some protection when young girls are at risk of being taken overseas for FGM. The article contains diagrams of the main types of FGM, and the steps of de-infibulation.]
- Van Wagner, V. (2004). Thinking through the debate about caesarean section "On Demand". Part I: Thinking about choice. Part II: Thinking about risk. *Canadian Journal of Midwifery Research & Practice, 3*(1), 12-28. [Midwives have an important role to play in emphasizing that the safest system of care would support low intervention approaches to vaginal birth for the majority of women. The overwhelming reason women choose caesarean section is fear and anxiety about birth. The request for caesarean surgery "on demand" can be seen, in part, as a call to improve care for pregnant women and vaginal birth. There is a problem with the system that would claim to offer choice of 'mode of birth' but fails to address the need to ensure that all choices of mode of birth are offered. The health care system does not normally offer surgery without medical indication, and patient autonomy allows for refusal of treatment but not compliance with a demand for unnecessary treatment. Physicians never get sued for doing a caesarean section but may well get sued for trying to avoid one. The prevention of one major adverse outcome would require 1591 caesareans and cost $2.4 million. High rates of caesarean sections are not associated with lower perinatal mortality, and a decrease in cerebral palsy. To understand the long-term impact of caesarean section, risks in subsequent pregnancies also need to be taken into account. With a repeat elective caesarean section the ECPC figure for maternal mortality is 17.9 per 100,000 as compared to 4.9 for vaginal birth. In some systems physicians directly benefit from higher fees for caesarean sections, so some governments pay a global fee for all births.]

Infections

- D'Amico, C. J., DiNardo, C. A., Krystofiak, S. (2004). Preventing contamination of breast pump kit attachments in the NICU. *MIDIRS Midwifery Digest, 14*(2), 246-251. [From the 2003 issue of *Journal of Perinatal and Neonatal Nursing, 17*(2), 150-157. Breast pumps are frequently used in a NICU. When a rubber bulb breast pump was used there was no adequate way to sterilize the pump bulbs, so it was recommended that milk be collected by manual expression directly into a sterile bottle whenever possible. The use of electric breast pumps should be restricted, the use be tracked, and they should be examined at regular intervals for contamination. Mothers should be supplied with sterile collection equipment and instructed on proper cleaning and usage. From the studies discussed, the conclusion was that further research is needed to determine the ideal cleaning for breast pump collection attachments. There are conflicting reports of what level of contamination of breast milk is acceptable. Several studies showed the most common organism to be coagulase-negative staphylococci.]
- Hadden, R. (2004). What nurses need to know. Hepatitis C and pregnancy. *AWHONN Lifelines, 8*(3), 226-231. [In Canada there have been estimates that up to 1 in 120 deliveries may occur in a woman who has HCV infection. Most individuals with HCV are unaware that they are infected. Spontaneous clearance of the virus after 6 to 12 months of infection is very rare. In pregnancy, vertical transmission, or maternal-infant transmission, is uncommon but not absent. When a baby is born to an HCV-infected woman, the baby must be tested for the presence of hepatitis C infection. NIH (2002) recommendations are: HCV RNA tests on two occasions between 2 and 6 months and/or have an anti HCV test done after 15 months of age. Sources state that the maternal antibodies do not disappear until 18 months of age. The long term consequences of HCV infections in children are largely unknown.]
- Jones, D. (2004). Understanding why women decline HIV testing. *RCM Midwives Journal, 7*(8), 344-347. [Newham Healthcare NHS Trust underwent an audit to explore why 12% of women declined HIV testing. Universal screening provides health benefits to both mother and fetus/baby, which include a decrease in maternal and fetal morbidity and mortality. Successful uptake of testing depends on the midwife's communication skills and how she introduces the subject, as well as the woman's perceptions and knowledge of HIV. It was found that women associated 'fear' with testing: fear of disclosure, abandonment, of the community knowing, and of death. Women refused to consider testing, did not believe that they were at risk, they had been tested sometime previously, only considered it necessary if being sexually active and 'sleeping around', wanted partner's permission, or gave no specific reason. So as not to appear biased all maternity care providers should have a policy of recommending HIV testing as a routine part of antenatal screening program along with rubella and hepatitis B screening tests. Women need to know that their HIV status is safe from their family including the partner. Midwives need to be non-judgemental.]

Postpartum Care

- Bates, C., & Paeglis, C. (2004). Motherhood and mental illness. *RCM Midwives Journal, 7*(7), 286-287. [Epidemiological studies of postnatal depression (PND) indicate a prevalence of between 10% and 15% and many cases go undetected. Mothers are more at risk of dying from suicide during a relapse of mental illness than from any other medical problem. There is a need for greater awareness among midwives of the risk of mental illness in order to provide adequate safeguards for mothers and babies. A British report

from an independent inquiry into the death of a mother and baby found that there is stigma surrounding mental health which may affect a career. A protocol is needed for doctor-to-doctor consultations. The mother's bipolar disorder should have alerted that a relapse was almost inevitable. Child protection guidance and training to alert relatives to monitor the mother and baby. Racism is considered to be an issue. The occupational health services knew the mother's psychiatric history but no action, advice or support were instigated for her. Health professionals need training about mental illness. This is reported in the *British Medical Journal,* BMJ 2003;327:1008 (1 November) at http://bmj.bmjjournals.com/cgi/content/full/327/7422/1008-d also the North East London inquiry reports into the death of Daksha Emson at http://www.nelondon.nhs.uk/publications.htm]

- Goodman, J. H. (2004). Postpartum depression beyond the early postpartum period. *JOGNN, 33*(4), 410-420. [A review of literature regarding postpartum depression and postpartum symptoms. (Articles are displayed in a table.) This depression usually occurs during the first postpartum months, compromising maternal functioning, and the development of mother-infant relationship. But, sometimes the onset occurs later in the first postpartum year. For a high percentage of women, depression continues well into the second year and beyond. There is the potential for chronicity which has deleterious effects on women and their families.]
- Nichols, M. R., & Roux, G. M. (2004). Maternal perspectives on postpartum return to the workplace. *JOGNN, 33*(4), 463-471. [Mothers found returning to the workforce as having more challenges than they expected because the experience was viewed as being mostly negative. Research is needed to identify resources and interventions which will assist working mothers.]
- Radford, A. (2004, Spring). Three to a bed: It's happening more often than you think. *Midwifery Connections*, p. 8. [Bed-sharing is associated with longer and more restful infant and maternal sleep, also with successful breastfeeding. There is an association with Sudden Infant Death Syndrome (SIDS) if parents are smokers or have impaired consciousness through exceptional tiredness, drug taking or alcohol consumption. SIDS is also associated with overheating, sleeping prone and the head becoming inadvertently covered. As a study found a very small risk of SIDS amongst other babies the Foundation for the Study of Infant Deaths changed its guidelines to recommend against bed-sharing before eight weeks. UNICEF recommends that parents be given clear evidence-based information about the benefits, risks and alternatives to bed sharing. See: http://www.babyfriendly.org.uk/bedshare.asp]
- Wroblewski, M., & Tallon, D. (2004). Implementing a comprehensive postpartum depression support program. *AWHONN Lifelines, 8*(3), 248-252. [Postpartum depression (PPD) is more common than gestational diabetes, preeclampsia, and preterm delivery. The cause of PPD is multi-factorial including biological, psycho-social and life situation stresses. Untreated PPD may have significant effects on mother, infant and family. The mother may develop more chronic and refractory mood disorders.]

<u>Neonatal Care</u>

- Arfi, C. (2004). Skincare for baby naturally. *MIDIRS Midwifery Digest, 14*(2), 243-244. [From the March 2004 issue of *Essence, 40*(2), 5-6. Pure essential oils are extremely powerful, so it is always preferable to see out pre-blended products that offer effective and safe preparations for young babies. Using just water for at least the first few weeks of

the baby's life, may be best. For dry scalp conditions, choose a sulphate-free shampoo product. A gentle scalp massage will help improve circulation and offer baby some additional relaxation. Shampoo once or twice a week is ample for young babies. Avoid baby's eyes regardless of how 'tear-free' a product claims to be. Do not use adult toiletry products which usually have higher amounts of perfumes, alcohols, added colours and other ingredients which can be irritating to an infant's thin skin.]

- Cockey, C. D. (2004). Babies born at risk for nerve damage with mothers who drink. *AWHONN Lifelines, 8*(3), 197. [Newborn babies whose mothers drank alcohol heavily during pregnancy had damage to the nerves in the arms and legs. The damage was still present when the children were reexamined at one year of age. The study is reported in the March issue of the *Journal of Pediatrics*.]

<u>Breastfeeding</u>

- Finigan, V. (2004). Breastfeeding - the great divide. The controversy as seen through a midwifery lens. *MIDIRS Midwifery Digest, 14*(2), 227-231. [Midwives have a responsibility to provide information to enable women to make a choice about feeding their baby. Midwives need to have sound clinical and theoretical knowledge so that they can empower new mothers. Breast milk enhances health by the type and amount of fats, proteins, sugars, minerals and vitamins, which change from feed to feed to meet the nutritional requirement and developmental needs of the individual baby. No two mothers will have the same constituents within their milk. Formula fed babies are more likely to be admitted to hospital with diarrhoea, chest infection, to have a middle ear infection, a urine infection, to develop eczema, if premature to suffer a rare but serious condition, to be at risk of sudden infant death syndrome, and to have reduced cognitive development and decreased visual acuity. One citation http://www.pediatrics.org/cgi/content/full/109/3/e42]
- Lee, B. (2004). Breastfeeding: State of the art. February 2004 Forum on Maternity and the Newborn of the Royal Society of Medicine. *RCM Midwives Journal, 7*(7), 306-309. [The Forum report can be read on www.motherhood.org.uk . Mary Renfrew presented "Enabling women to breastfeed - the evidence from systematic reviews". Breastfeeding is an important and effective intervention with multiple benefits: less mortality in premature babies, less gastroenteritis, atopic disease, respiratory disease, urinary tract infection, otitis media, and hospitalisation in infancy. Other risks are reduced: diabetes and obesity in childhood, adult disease, including cardiovascular disease and Crohn's disease. IQ is increased and there are benefits for maternal health and the mother-baby relationship. Much research in this area is flawed, though improving. In the study *Looking at Infant Feeding Today* few participants in focus groups were aware of the disadvantages of artificial feeding. Breastfeeding in public was a predominant issue as it was seen as providing voyeuristic pleasure for men who are not their partners, and many men confirmed this. Research among low-income groups is very limited. There are problems of literacy, language and culture, and poor response to postal questionnaires - these are groups that move house frequently. Louise Wallace spoke on "Developing local breastfeeding strategies for PCTs: Use of research evidence". Philippa Parrett and Suzanne Colson spoke on "Biological nurturing - a new approach to breastfeeding".

Maternal concentrations of oxytocin are higher immediately after birth than at any time during labour. An increase in oxytocin release on the second day postpartum is associated with longer duration of breastfeeding. Prolactin directs maternal love toward the baby and its blood levels peak within 30 to 45 minutes of the start of a breastfeed. Mothers giving birth by caesarean section lack a significant rise in prolactin levels at 20 to 30 minutes from the start of a breastfeed.]

Family Planning

- Harvey, S. M., Bird, S. T., & Branch, M. R. (2004). A new look at an old method: The diaphragm. *MIDIRS Midwifery Digest, 14*(2), 239-242. [From the November/December 2003 issue of *Perspectives on Sexual and Reproductive Health, 35*(6), 270-273. The vaginal diaphragm was invented in 1842. It is a female-controlled method for women to protect themselves against HIV and other STDs (which are more common than HIV). There is a lower risk of infection among user of female-controlled devices than among condom users.]

Women's Health

- Clinical Issues. (2004). Promoting positive birth experiences. *JOGNN, 33*(4), 484-518. [There are three articles in addition to the introduction . Storytelling is an old means of integrating transformative moments in the human experience. (The Midwifery Way forum, heard this from Ami McKay of Nova Scotia http://www.amimckay.com).]
- Cockey, C. D. (2004). Should diabetics be taking statins. New guidelines say so and call for aggressive management to prevent heart disease. *AWHONN Lifelines, 8*(3), 192-193. [Published in the April 20 issue of *Annals of Internal Medicine*, available at www.annals.org .]
- Cockey, C. D. (2004). WHI study finds increased stroke risk with estrogen alone. *AWHONN Lifelines, 8*(3), 193-194. [The multicentred Women's Health Initiative found that estrogen-alone hormone therapy had no effect on coronary heart disease risk but increased the risk of stroke for postmenopausal women, increased the risk of deep vein thrombosis, had no significant effect on the risk of breast or colorectal cancer and reduced the risk of hip and other fractures. The estrogen-alone study was stopped at the end of February 2004. Initial findings reported in the April 14 issue of the *Journal of the American Medical Association*.]
- Cockey, C. D. (2004). NSAIDS may hamper fertility. *AWHONN Lifelines, 8*(3), 195-196. [Australian doctors found that COX-2 inhibitors (NSAIDS which include Celebrex and Vioxx) can impair fertilization, embryo development, implantation and continuing pregnancy. Reported in the editorial of the March issue of *Fertility and Sterility*.]
- Cockey, C. D. (2004). New eggs continue to develop in adult mice. *AWHONN Lifelines, 8*(3), 196-198. [The long held theory that the number of oocytes (eggs) in the ovaries of most mammals is fixed at birth is being challenged by scientists who have found that oocyte-containing follicles continue to develop in the ovaries of adult mice. Reported in the March 11 issue of *Nature*.]

Research and Methods

- Mayberry, L. J., & Lowe, N. K. (2004). Systematic reviews of research. Editorial. *JOGNN, 33*(4), 409. [Systematic reviews present the results of a preplanned approach to a critical review of a group of studies by one or more professionals who have both scientific and content expertise. Information may be obtained from http://www.cochrane.org/reviews/clibintro.htm ; from the Centre for Evidence-based Medicine at http://www.cebm.net/levels_of_evidence.asp ; the Centre for Reviews and Dissemination http://www.york.ac.uk/inst/crd/crdreview.htm ; the Agency for Health Care Research and Quality http://www.ahrq.gov]
- O'Connell, R. L., Gebski, V. J., & Keech, A. C. (2004). Making sense of trial results: Outcomes and estimation. *MIDIRS Midwifery Digest, 14*(2), 276-278. [From February 2, 2004 issue of *Medical Journal of Australia, 180*, 128-130. What would be a clear explanation of how to interpret research findings has been reduced by the way that the article has been summarized. Some of the boxed examples have been omitted.]
- Rogers, J., & Wood, J. (2004). Benefits for all: Involving midwives in clinical trials. *RCM Midwives Journal, 7*(7), 291-293. [For the Hinchingbrooke third-stage trial (between 1993-1996) people were aware of the progress in the trial by a notice board and a six monthly newsletter. The way corporate decisions were made was usually specific and inclusive. The midwives were asked to choose whether to evaluate syntometrine or syntocinon. Their choice was syntometrine, so this was the drug used during the trial. {This drug is rarely used here}.]
- Sakala, C. (2004). Resources for evidence-based practice, July/August 2004. *JOGNN, 33*(4), 480-483. [Resources used are the free http://www.update-software.com/cochrane/ http://www.york.ac.uk/inst/crd/darehp.htm ; http://www.nice.org.uk/cat.asp?c=89310 http://www.who.int/reproductive-health/rhl/ Also, the abstracts from many journal articles may be obtained on-line.]

Alternatives

- Gaffney, L., & Smith, C. A. (2004). Use of complementary therapies in pregnancy: The perception of obstetricians and midwives in South Australia. *MIDIRS Midwifery Digest, 14*(2), 271-275. [From the 2004 issue of *Australian and New Zealand Journal of Obstetrics & Gynaecology, 44*, 24-29. Evidence from the Cochrane review suggests that acupuncture and hypnosis may be beneficial for the management of pain during labour, but data are limited and further research is needed. Questionnaires were completed, and the majority of obstetricians considered massage, acupuncture, vitamins, yoga, meditation and hypnosis to be useful during pregnancy, but nearly half considered homeopathy, aromatherapy, herbal therapies and naturopathy as not useful, or had no opinion. Midwives held strong beliefs that massage, yoga, meditation, acupuncture, aromatherapy, herbal therapy and hypnosis were useful during pregnancy. Many midwives held no opinion on the usefulness of chiropractic, naturopathy and homeopathy during pregnancy.]

Independent Midwives www.independentmidwives.org.uk then click on members resources, and click on news and articles, for information about the UK independent midwives.

An update of the Memorial University Library Acquisitions for 2003/2004

Given below is the annual list of Memorial University's new resources which may be of particular interest to members of the Association of Midwives. This is the tenth update since 1994, when the original list covering materials obtained in the previous 10 years was printed in the 1994 Newsletters. Once again we have to thank Linda Barnett of the Health Sciences Library for retrieving the information for us. The items have not been checked, and so for some of those listed the author may have used terminology in other than a physiological sense.
(HEALTH = Health Sciences Library, QEII = Queen Elizabeth II Library, CNS = Centre for Newfoundland Studies, GRENFELL = Sir Wilfred Grenfell College, Corner Brook).

Childbearing

Abou Zahr, Carla, & Tessa Wardlaw. (2003). Antenatal care in developing countries : promises, achievements and missed opportunities : an analysis of trends, levels and differentials, 1990-2001 / Geneva : World Health Organization ; New York : UNICEF.
CALL NUMBER: WQ 175 A155A 2003 LOCATION: HEALTH

Bankowski, Brandon J. et al. (2002). The Johns Hopkins manual of gynecology and obstetrics / Department of Gynecology and Obstetrics, Johns Hopkins University, School of Medicine, Baltimore, Maryland ; Philadelphia : Lippincott, Williams & Wilkins.
CALL NUMBER: WQ 39 J65 2002 LOCATION: HEALTH

Belfort, Michael A., Steven Thornton, and George R. Saade. (Eds.). (2003). Hypertension in pregnancy / New York : Marcel Dekker.
CALL NUMBER: WQ 244 H998 2003 LOCATION: HEALTH

Bellenir, Karen. (Ed.). (2002). Depression source book : basic consumer health information about unipolar depression, bipolar disorder, postpartum depression, seasonal affective disorder, and other types of depression in children, adolescents, women, men, the elderly, and other selected populations / Detroit, Mich. : Omnigraphics.
CALL NUMBER: RC 537 D4455 2002 LOCATION: QEII

Births, deaths and marriages in Newfoundland newspapers 1810-1890. (2004). [electronic resource]. St. John's, N.L. : Memorial University of Newfoundland, Maritime History Archive.
CALL NUMBER: HA 747 N4 B57 2004 LOCATION: QEII
CALL NUMBER: HA 747 N4 B57 2004 LOCATION: GRENFELL
CALL NUMBER: HA 747 N4 B57 2004 LOCATION: CNS

Black, Martin M. et al. (2002).Obstetric and gynecologic dermatology / London ; Toronto : Mosby.
CALL NUMBER: WP 17 O27 2002 LOCATION: HEALTH

Bourgeault, Ivy Lynn, Cecilia Benoit & Robbie Davis-Floyd. (Eds.). (2004). Reconceiving midwifery / Montreal : McGill-Queen's University Press.
CALL NUMBER: RG 950 R42 2004 LOCATION: CNS

Canadian Institute for Health Information. (2004). Giving birth in Canada: providers of maternity and infant care. Ottawa, ON., Canadian Institute for Health Information.
CALL NUMBER:Shelved by series title and vol. number LOCATION: HEALTH - INTERNET

Christie, D. A., & E. M. Tansey.(Eds.). (2001). Maternal care : witness seminar transcript / London : Wellcome Trust Centre for the History of Medicine at UCL. (Wellcome witnesses to twentieth century medicine ; v. 12).
CALL NUMBER: WZ 64 W447 V.12 LOCATION: HEALTH

Creasy, Robert K., Robert Resnik, & Jay D. Iams. (Eds.). (2004). Maternal-fetal medicine : principles and practice / Philadelphia, Pa. : W.B. Saunders Co.
CALL NUMBER: WQ 211 M425 2004 LOCATION: HEALTH

Creatsas, George, George Mastorakos, & George P. Chrousos. (Eds.). (2003).Women's health and disease : gynecologic and reproductive issues / New York : New York Academy of Sciences. (*Annals of the New York Academy of Sciences* ; v. 997)
CALL NUMBER: Shelved by series title and vol. number LOCATION: HEALTH periodical

Danforth's obstetrics and gynecology. (2003). Philadelphia : Lippincott Williams & Wilkins.
CALL NUMBER: WQ 100 D1812 2003 LOCATION: HEALTH

De Swiet, Michael. (Ed.). (2002). Medical disorders in obstetric practice / Malden, Mass. : Blackwell Science.
CALL NUMBER: WQ 240 M489 2002 LOCATION: HEALTH

Douglas, Susan Jeanne, & Meredith W. Michaels. (2004). The mommy myth : the idealization of motherhood and how it has undermined women / New York : Free Press.
CALL NUMBER: HQ 759 D67 2004 LOCATION: QEII

Dundes, Lauren. (Ed.). (2003). The manner born : birth rites in cross-cultural perspective / Walnut Creek, CA : AltaMira Press.
CALL NUMBER: GN 482.1 M36 2003 LOCATION: QEII

Fox, Harold, and Michael Wells. (Eds.). (2003). Haines & Taylor obstetrical and gynaecological pathology / Edinburgh : Churchill Livingstone.
CALL NUMBER: WP 140 H3G 2003 V.1 LOCATION: HEALTH
CALL NUMBER: WP 140 H3G 2003 V.2 LOCATION: HEALTH

Gilbert, Elizabeth Stepp, & Judith Smith Harmon. (2003). Manual of high risk pregnancy & delivery / St. Louis, Mo. : Mosby.
CALL NUMBER: WY 157 G464M 2003 LOCATION: HEALTH

Gottfried, Heidi and Laura Reese. (Ed.). (2004). Equity in the workplace : gendering workplace policy analysis / Lanham : Lexington Books. (Studies in public policy)
CALL NUMBER: HD 6060 E67 2004 LOCATION: QEII

Green, Carol J., & Judith M. Wilkinson. (2004). Maternal newborn nursing care plans / St. Louis, MO : Mosby.
CALL NUMBER: WY 157.3 G795M 2004 LOCATION: HEALTH

Greer, Ian A. Et al. (2003). Problem-based obstetrics and gynaecology / Edinburgh ; Toronto : Churchill Livingstone.
CALL NUMBER: WQ 18.2 P962 2003 LOCATION: HEALTH

Health Canada.(2003).Why all women who could become pregnant should be taking folic acid [electronic resource]. [Ottawa] : Health Canada.
CALL NUMBER: INTERNET

Health Canada. (2004). Canadian Perinatal Surveillance System. Physical abuse during pregnancy. [Ottawa].
CALL NUMBER: WA 900 DC2 C218PB LOCATION: REFERENCE
CALL NUMBER: WA 900 DC2 C218PB LOCATION: HEALTH
CALL NUMBER: WA 900 DC2 C218PB LOCATION: HEALTH

Human Resources Development Canada. (2002). Pamphlet [electronic resource] 5, Maternity-related reassignment and leave, maternity leave and parental leave. [Gatineau, Quebec] : Human Resources Development Canada.
CALL NUMBER: INTERNET

Koch, Richard, Felix de la Cruz, & Colleen G. Azen. (Eds.). (2003). The Maternal Phenylketonuria Collaborative Study : new developments and the need for new strategies, April 11-12, 2003 Lister Hill Auditorium, Bethesda, Md. / [Evanston, Ill.] : American Academy of Pediatrics. (*Pediatrics,* v. 112, no. 6, pt. 2, suppl.)
CALL NUMBER: Shelved by series title and vol. number LOCATION: HEALTH periodical

Kohner, Nancy, & Alix Henley. (2001). When a baby dies : the experience of late miscarriage, stillbirth and neonatal death / London ; New York : Routledge.
CALL NUMBER: WQ 225 K79W 2001 LOCATION: HEALTH

Kohut, Ruth and I.D. Rusen. (2002). Congenital anomalies in Canada : a perinatal health report [Ottawa] : Canadian Perinatal Surveillance System.
CALL NUMBER: QS 675 K64C 2002 LOCATION: HEALTH INTERNET

Layne, Linda L. (2003). Motherhood lost : a feminist account of pregnancy loss in America / New York : Routledge.
CALL NUMBER: HQ 759 L379 2003 LOCATION: QEII
CALL NUMBER: HQ 759 L379 2003 LOCATION: GRENFELL

Lee, Ellie. (2003). Abortion, motherhood, and mental health : medicalizing reproduction in the United States and Great Britain / Hawthorne, N.Y. : Aldine de Gruyter. (Social problems and social issues)
CALL NUMBER: HQ 767.5 U5 L42 2003 LOCATION: QEII

Lowdermilk, Deitra Leonard, & Shannon E. Perry. (Eds.). (2004). Maternity & women's health care / St. Louis, Mo. : Mosby.
CALL NUMBER: WY 157.3 M425 2004 LOCATION: HEALTH
CALL NUMBER: WY 157.3 M425 2004ZCD-ROM LOCATION: HEALTH

Luttrell, Wendy. (2003). Pregnant bodies, fertile minds : gender, race, and the schooling of pregnant teens / New York : Routledge.
CALL NUMBER: LC 4091 L88 2003 LOCATION: QEII

MacLean, Allan B., & James Neilson. (Eds.). (2002). Maternal morbidity and mortality / London : RCOG Press.
CALL NUMBER: WA 900.1 M4247 2002 LOCATION: HEALTH

Mander, Rosemary and Valerie Fleming. (Eds.). (2002). Failure to progress : the contraction of the midwifery profession / London ; New York : Routledge.
CALL NUMBER: WQ 160 F161 2002 LOCATION: HEALTH

Manning, Melanie. (2003). Pregnancy, the workplace and the law / Aurora, Ont. : Canada Law Book.
CALL NUMBER: KE 3352 M36 2003 LOCATION: QEII

McHaffie, Hazel, Peter W. Fowlie et al. (2001). Crucial decisions at the beginning of life : parents' experiences of treatment withdrawal from infants / Abingdon : Radcliffe Medical.
CALL NUMBER: W 50 M47843C 2001 LOCATION: HEALTH

Miller, Hugh Stephen, and Jo A. Griffith. (2003). Instructions for obstetric and gynecologic patients / Philadelphia : Saunders.
CALL NUMBER: WQ 150 M648I 2003 LOCATION: HEALTH
CALL NUMBER: WQ 150 M648I 2003 CD-ROM LOCATION: HEALTH

Morgan, Mark, & Sam Siddighi. (Eds.). (2004). Obstetrics and gynecology / Philadelphia : Lippincott Williams & Wilkins. (National medical series for independent study).
CALL NUMBER: WQ 18.2 O14 2004 LOCATION: HEALTH

Nelson, Jennifer. (2003). Women of color and the reproductive rights movement / New York : New York University Press.
CALL NUMBER: HQ 766.5 U5 N45 2003 LOCATION: QEII

Newfoundland and Labrador Centre for Health Information. (2003). Live birth trends, health and community services and integrated boards, Newfoundland and Labrador, 1997-2001 / Newfoundland and Labrador Centre for Health Information. St. John's, N.L.
CALL NUMBER: WA 900 DC2.1 N4 L784 1997-2001 LOCATION: HEALTH
CALL NUMBER: HB 940 N4 L57 2003 LOCATION: CNS

Pacelle, Richard L. (2003). Between law & politics : the Solicitor General and the structuring of race, gender, and reproductive rights litigation / College Station : Texas A&M University Press. (Presidency and leadership ; no. 14)
CALL NUMBER: KF 8790 P33 2003 LOCATION: QEII

Pearlman, Mark D., Judith E. Tintinalli, & Pamela L. Dyne. (Eds.). (2004). Obstetric & gynecologic emergencies : diagnosis and management / New York : McGraw-Hill, Medical Pub. Division.
CALL NUMBER: WP 39 O14 2004 LOCATION: HEALTH

Perspectives on sexual and reproductive health [electronic resource]. (2002). New York, NY : Alan Guttmacher Institute.
CALL NUMBER: INTERNET

Rankin, Jean. (2002). Effects of antenatal exercise on psychological well-being, pregnancy and birth outcome / London : Whurr. (Nursing research)
CALL NUMBER: WQ 200 R26E 2002 LOCATION: HEALTH

Rodeck, Charles. (2003). Pregnancy : reducing maternal death and disability / Oxford : Oxford University Press. (*British medical bulletin* ; v. 63).
CALL NUMBER: Shelved by series title and vol. number LOCATION: HEALTH periodical

Rosen, Robyn L. (2003). Reproductive health, reproductive rights : reformers and the politics of maternal welfare, 1917-1940 / Columbus : Ohio State University Press.
CALL NUMBER: HV 699 R66 2003 LOCATION: QEII

Simpson, Joe Leigh, & Sherman Elias. (2003). Genetics in obstetrics and gynecology / Philadelphia : Saunders.
CALL NUMBER: QZ 50 G3276 2003 LOCATION: HEALTH

Squires, Susan E. G. (2003). Age and individual differences in infant visual attention and oral exploration during an object examination task.
CALL NUMBER: MICRO FICHE 6064 LOCATION: CNS
CALL NUMBER: Request by author's name and title LOCATION: CNS Thesis

Stanley, Nicky et al. (2003). Child protection and mental health services : interprofessional responses to the needs of mothers / Bristol, UK : Policy Press.
CALL NUMBER: HV 751 A6 C5782 2003 LOCATION: QEII

Stuart, Ci Ci. (2003). Assessment, supervision and support in clinical practice : a guide for nurses, midwives and other health professionals / Edinburgh : Churchill Livingstone.
CALL NUMBER: WY 105 S929A 2003 LOCATION: HEALTH

Vontver, Louis A et al. (2003). Appleton & Lange review obstetrics & gynecology / New York ; Toronto : Appleton & Lange Reviews/McGraw-Hill, Medical Publishing Division.
CALL NUMBER: WP 18.2 V948P 2003 LOCATION: HEALTH

Walley, R. et al. (2001). Surgical and nursing management of obstetric fistulae [electronic resource] / produced by the Multimedia Instructional Development Centre, Faculty of Medicine, Memorial University of Newfoundland, St. John's, Newfoundland, Canada. St. John's, Nfld. : Matercare International. [Kay Matthews].
CALL NUMBER: WP 180 W199S 2001 LOCATION: HEALTH

Washington Clark Hill. (Ed.). (2002). Ambulatory obstetrics / Philadelphia ; London : Lippincott Williams & Wilkins.
CALL NUMBER: WQ 240 A497 2002 LOCATION: HEALTH

Wendel, Helmut F., Christopher S. Wendel, Katherine A. DeBrandt, Mary Meghan Ryan, & Mark Siegal. (Eds.). (2004).Vital statistics of the United States : births, life expectancy, deaths and selected health data / Lanham, MD : Bernan Press.
CALL NUMBER: WA 900 AA1 V836 2004 LOCATION: HEALTH

Wilkie, Laurie A. (2003). The archaeology of mothering : an African-American midwife's tale / New York : Routledge.
CALL NUMBER: RG 950 P474 W54 2003 LOCATION: QEII

Williams, Sue Rodwell and Eleanor D. Schlenker. (2003). Essentials of nutrition & diet therapy / St. Louis, Mo. : Mosby.
CALL NUMBER: WB 400 W5E 2003 LOCATION: HEALTH
CALL NUMBER: WB 400 W5E 2003 CD-ROM LOCATION: HEALTH

Wylen, Michelle. (Ed.). (2004). Obstetrics and gynecology : PreTest self-assessment and review / New York ; Toronto : McGraw-Hill, Medical Pub. Division.
CALL NUMBER: WP 18.2 O37 2004 LOCATION: HEALTH

Neonatal/Fetal

Cloherty, John P., Eric C. Eichenwald, & Ann R. Stark.(Eds.). (2004). Manual of neonatal care / Philadelphia : Lippincott Williams & Wilkins.
CALL NUMBER: WS 420 M293 2004 LOCATION: HEALTH

Christie, D. A., & E. M Tansey. (Eds.). (2001). Origins of neonatal intensive care in the UK : a witness seminar held at the Wellcome Institute for the History of Medicine, London, on 27 April, 1999 : witness seminar transcript / London : Wellcome Trust. (Wellcome witnesses to twentieth century medicine ; v. 9)
CALL NUMBER: WZ 64 W447 V.9 LOCATION: HEALTH

Czervinske, Michael P., & Sherry L. Barnhart. (Eds.). (2003). Perinatal and pediatric respiratory care / Philadelphia ; Toronto : Saunders.
CALL NUMBER: WS 280 P445 2003 LOCATION: HEALTH

Early diagnosis of inherited metabolic disorders : towards improving outcome. (2003). Secaucus, N.J. : Springer-Verlag New York Inc. (*European journal of pediatrics* ; v. 162, suppl. 1)
CALL NUMBER: Shelved by series title and vol. number LOCATION: HEALTH periodical

Erickson, Barbara. (2003). Heart sounds and murmurs across the lifespan / St. Louis : Mosby. CALL NUMBER: WG 18.2 E68H 2003 LOCATION: HEALTH
CALL NUMBER: WG 18.2 E68H 2003 PT.X LOCATION: HEALTH

Goldsmith, Jay P., & Edward H. Karotkin. (Ed.). (2003). Assisted ventilation of the neonate / Philadelphia, PA : Saunders.
CALL NUMBER: WS 420 A848 2003 LOCATION: HEALTH

Gomella , Tricia Lacy (Ed.). (2004). Neonatology : management, procedures, on-call problems, diseases, and drugs / New York ; Toronto : Lange Medical Books/McGraw-Hill, Medical Publishing Division. (A Lange clinical manual)
CALL NUMBER: WS 39 N438 2004 LOCATION: HEALTH

Gopnik, Alison, Andrew Meltzoff, and Patricia Kuhl. (2001). How babies think : the science of childhood / London : Phoenix.
CALL NUMBER: BF 720 C63 G67 2001 LOCATION: QEII

Greenough, Anne, & Anthony D. Milner. (Eds.). (2003). Neonatal respiratory disorders / London : Arnold ; New York : Distributed in the U.S.A. by Oxford University Press.
CALL NUMBER: WS 421 N4385 2003 LOCATION: HEALTH

Health Canada. (2003). Fetal alcohol spectrum disorder (FASD) : a framework for action. Ottawa : Health Canada..
CALL NUMBER: RG 629 F45 F46 2003 LOCATION: QEII - INTERNET

Hoath, Steven B., & Howard I. Maibach. (Eds.). (2003). Neonatal skin : structure and function / New York : M. Dekker.
CALL NUMBER: WR 102 N46 2003 LOCATION: HEALTH

Hoffmann, Georg F. Et al. (2002). Inherited metabolic diseases / Philadelphia : Lippincott Williams & Wilkins. (Core handbooks in pediatrics) .
CALL NUMBER: WD 200.1 I55 2002 LOCATION: HEALTH

Merenstein, Gerald B., and Sandra L. Gardner. (Eds.). (2002). Handbook of neonatal intensive care / St. Louis : Mosby.
CALL NUMBER: WS 421 H236 2002 LOCATION: HEALTH

Schechter, Neil L., Charles B. Berde, & Myron Yaster. (Eds.). (2003). Pain in infants, children, and adolescents / Philadelphia : Lippincott Williams & Wilkins.
CALL NUMBER: WL 704 P148 2003 LOCATION: HEALTH

Stevenson, David K., William E. Benitz, and Philip Sunshine. (Eds.). (2003). Fetal and neonatal brain injury : mechanisms, management, and the risks of practice / Cambridge ; New York : Cambridge University Press.
CALL NUMBER: WS 340 F419 2003 LOCATION: HEALTH

Taketomo, Carol K., Jane H. Hodding, & Donna M. Kraus. (2002). Pediatric dosage handbook : including neonatal dosing, drug administration & extemporaneous preparations, 2002-2003 / Hudson, OH : Lexi-Corp.
CALL NUMBER: WS 366 S558D 2002 LOCATION: HEALTH

Wigle, Donald T. (2003). Child health and the environment / Oxford ; Toronto : Oxford University Press.
CALL NUMBER: WA 671 W658C 2003 LOCATION: HEALTH

World Health Organization. (2003). Managing newborn problems : a guide for doctors, nurses, and midwives / Geneva : World Health Organization, Dept. of Reproductive Health and Research. (Integrated management of pregnancy and childbirth).
CALL NUMBER: WS 420 M266 2003 LOCATION: HEALTH - INTERNET

Yagel, Simcha, Norman H. Silverman, and Ulrich Gembruch. (2003). Fetal cardiology : embryology, genetics, physiology, echocardiographic evaluation, diagnosis and perinatal management of cardiac diseases / London ; New York : Martin Dunitz.
CALL NUMBER: WS 290 F4193 2003 LOCATION: HEALTH

Zhao, Yong. (2002). Developmental changes in antioxidant enzymes and the effects of high O2 after birth on enzyme activity.
CALL NUMBER: MICRO FICHE 6034 LOCATION: CNS
CALL NUMBER: Request by author's name and title LOCATION: CNS Thesis

Infant Feeding

American Dietetic Association. (2004). The Feeding Infants and Toddlers Study (FITS). Chicago, Ill. : American Dietetic Association. (*Journal of the American dietetic association* ; v. 104, no. 1, suppl. 1)
CALL NUMBER: Shelved by series title and vol. number LOCATION: HEALTH periodical

Butte, Nancy Felicia, Mardia G. Lopez-Alarcon, & Cutberto Garza. (2002). Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life / Geneva : World Health Organization.
CALL NUMBER: WS 125 B988N 2002 LOCATION: HEALTH - INTERNET

Guesry, Pierre R., Clara Garcia-Rodenas,& Jean Rey. (2003). Nutrition and brain development of the infant / Basingstoke : Taylor & Francis. (*Acta paediatrica* ; v. 92, suppl. 442)
CALL NUMBER: Shelved by series title and vol. number LOCATION: HEALTH periodical

Harding, Scott V. (2003). Evaluation of the iron, antioxidant and dietary status of iron supplemented breastfed healthy infants.
CALL NUMBER: MICRO FICHE 5926 LOCATION: CNS
CALL NUMBER: Request by author's name and title LOCATION: CNS Thesis

World Health Organization. (2003). Global strategy for infant and young child feeding / Geneva : World Health Organization.
CALL NUMBER: WS 120 G5625 2003 LOCATION: INTERNET

Premature babies show long-term effects. *Nunatsiaq News*, August 20, 2004, page 15.
Babies who are born before their due dates can suffer long-term damage, researchers at Yale, Stanford and Brown University medical schools have found. Brain scans of eight-year-olds who were born around 28 weeks show significantly smaller brains than children who are carried full-term. One researcher called the smaller brain size "a striking and significant development abnormality." The damage was evident in parts of the brain responsible for reading, language, emotion and behaviour. Boys are more affected than girls.
A recent study in the Baffin region found pre-term birth rates that were three times the national average. The scientist behind that study cited STDs, cigarette smoking and high blood pressure as well as stress, anxiety and depression as recognized factors in pre-term births.
http://www.nunatsiaq.com Also see: January 9, 2004:
http://www.nunatsiaq.com/archives/40109/news/nunavut/40109_07.html

Breastfeeding Week 2004
Exclusive Breastfeeding: the Gold Standard, safe, sound, sustainable. The **GOLDEN BOW** is the symbol.
Gold: The use of the gold colour for the bow symbolises that breastfeeding is the "Gold Standard": the ideal, of exclusive and continued breastfeeding, against which any other alternative should be compared and judged.
A Bow: Why do we use a bow, rather than the looped ribbon of most campaigns? Each part of the bow carries a special message: One loop represents the mother and the other represents the child. The knot symbolises the father, family and society which support them. One of the ends is for timely complementary food after six months, the other is for the use of family planning to space births three to five years apart. The Golden Bow is a joint outreach initiative of UNICEF and WABA.
http://www.unicef.org/programme/breastfeeding/bow.htm
http://www.waba.org.my/forum2/goldenbow.html

American College of Nurse Midwives
The 2004 ACNM Annual Meeting in New Orleans was a tremendous success. The clinical education sessions provided a broad overview of many currently relevant topics. The "hot topics" that all advanced practice nurses working in perinatal care should keep on their radar screen include patient safety, evidence-based prenatal care, new methods of family planning, pelvic floor issues, and management of the third stage of labor. Throughout the meeting, emphasis was placed on evidence-based practice, and midwives were challenged to integrate new evidence into their clinical practice.
The impact of this challenge to embrace evidence-based practice raised the *big question* in the area of third-stage management: should CNMs consider active management of third-stage labor as the standard of care? The answer is a very clear *YES*! Maintaining the strength of the midwifery model of care and embracing and integrating into practice the ever-growing body of evidence will continue to keep midwives on the leading edge of providing safe, high quality, and satisfying healthcare for women.

Conferences As this information comes from a variety of sources the editor takes no responsibility for any errors.

2004

October 1-7, 2004. Canada Breastfeeding week. "Exclusive breastfeeding: The gold standard - safe, sound and sustainable."

October 15-16, 2004. "Breastmilk Production, Composition and Evidence Based Assessment of Human Lactation", Toronto. Peter Hartmann & Team Australia.
Contact: Beverly Sullivan, Sunnybrook & Women's College Health Sciences Centre, Neonatal & Perinatal Program.(Telephone: 416-323-6400 ext 4047; E-mail" beverly.sullivan@sw.ca ; Web site: http://www.sunnybrookandwomens.on.ca , click on Perinatal Breastfeeding Conference).

October 15-17, 2004. "Midwifery: A Bridge to the Sacred", MANA conference, Portland, Oregon.
Contact: info@mana.org

October 21-23, 2004. "Celebrating Diversity and Strength. The Fifth Canadian Rural Health Research Conference" and "The Fourth International Rural Nursing Congress", Sudbury, ON.
Cost: Early registration before September 1.
Contact: Donna Bentham (Telephone: 250-960-6409; E-mail: rrn@unbc.ca; Web site for Canadian Rural Health Research Society http://crhrs-scrsr.usask.ca/sudbury2004)

October 13, 2004. ARNNL 50th anniversary meeting, Holiday Inn, St.John's.

November 11-13, 2004. "Honouring our past, Embracing the present, Redesigning our future", AWHONN Canada 15th National Conference, Regina.
Contact: Susan Mussell, St. Boniface Hospital, D2045-409 Tache Avenue, Winnipeg, MB, R2H 2A6 (Fax: 204-233-1751; E-mail: smussell@sbgh.mb.ca).

November 21, 2004. Women's Health, HSC, St. John's.
Contact: Professional Development, Faculty of Medicine, MUN, Room 1775, Health Sciences Centre. (Telephone: 709-777-6653; Fax: 709-777-6032; E-mail: pdmed@mun.ca; Web-site: http://cme.med.mun.ca)

2005

March 17, 2005. "The management of early pregnancy complications and the perils of ectopic pregnancy". Joint RCN and Ectopic Pregnancy Trust conference, London, UK. Objectives are to raise awareness of ectopic pregnancy and its causes. Diagnosis of early pregnancy complications. Chlamydia and the impact on fertility.
Cost: RCN member £85/non-member £105.
Contact: Jeanette Staddon, Royal College of Nursing, Copse Walk, Cardiff Gate Business Park, Cardiff CF23 8XG, Wales. (Telephone: 011-44-29-2054-6493; Fax: 011-44-29-2054-6495; E-mail: womenshealth@rcn.org.uk ; Web-site: http://www.rcn.org.uk/events)

April 28-29, 2005. "Advances in Reproductive Health: Impacts and Outcomes", annual IWK Health Centre's Women's and Newborn Health Conference, Halifax.
Contact: Angela Fraser, Chair of Registration, Women's and Newborn Health, IWK Health Centre, 5850/5980 University Avenue, PO Box 9700, Halifax, NS B3K 6R8 (Telephone: 902-470-6943; Fax: 902-470-8101; E-mail: angela.fraser@iwk.nshealth.ca)

June 10-16, 2005. American College of Nurse Midwives Annual Meeting, 50th Anniversary.
Contact: ACNM, Telephone: 240-485-1800; Web site: http://www.midwife.org

July 24-28, 2005. "Midwifery: Diverse Pathways to Healthy Nations", ICM 27th Triennial Congress, Brisbane, Australia.
Contact: midwives2005@meetingplanners.com.au

New guidelines for baby death trials. Expert witness reform is ordered to prevent parents who lose their children being wrongly accused. Richard Alleyne. *Daily Telegraph*, September 7, 2004, p. 4. Submitted by Ann Chaulk.
Tough control over expert witnesses in cot death cases were ordered yesterday as part of steps designed to prevent parents from being wrongly accused of killing their babies. The self-styled experts should remember that they represented the cause of justice and not "a side" in the trials, the review said. They should also refrain from using the courtroom to "fly their personal kites" or "to push a theory from the far end of the medical spectrum", it added.
The report, chaired by the Labour peer Lady Helena Kennedy, QC, was drawn up after a number of mothers were wrongly convicted of murdering their babies. Sally Clark, Trupti Patel and Angela Cannings were all acquitted on appeal after being earlier convicted of killing two or more of their children. All three were accused chiefly on the evidence of Prof Sir Roy Meadow, who is said to have exaggerated the odds of multiple cot deaths when he claimed that the chances of two unexplained infant deaths in one family was one in 73 million. He is currently being investigated by the General Medical Council.
"Those who give medical evidence to courts have a duty to ensure that the foundation of that evidence is sound," the review said. "Unfortunately, doctors are occasionally drawn into error because they base their testimony on medical belief rather than scientific evidence. There is also the temptation, particularly in the very adversarial arena of the criminal courts, to be pushed into certainties where there are none. Barristers for the Crown hate the words 'I don't know', whereas the defence lawyer loves them. In criminal cases where guilt must be based on the high standard of proof beyond reasonable doubt, an expert's reservation may be the rock upon which a prosecution founders. However, the expert witness should constantly remind himself or herself that they are independent and not there to win for a side." The 73-page report, convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health, called for far more rigour in assessing evidence given by expert witnesses. Ultimate responsibility lay with the judges and barristers, who should be vigilant in making sure self-styled experts have the required knowledge and are not pushed into turning belief into fact. This could be helped by a pre-trial review of their evidence, the report said. But the experts themselves should also remember that they represented justice and owed a duty of impartiality. They must disclose any evidence that they knew disputed their opinion.
As well as expert witnesses, the publication - *Sudden Unexpected Deaths In Infancy* - set out recommendations on the whole investigation process. Inquests should be automatically held into all sudden infant deaths unless there was an immediately recognisable natural cause. At present it was at the discretion of the local coroner. The number of pathologists specialising in children should be doubled, the report said. There was a shortage of pathologists specialising in child death despite babies being four times more likely to die in the first year than at any other time in their lives. There were currently only 43 paediatric pathologists in the country to deal with 600 deaths. There were a further 40 forensic pathologists investigating criminal deaths but only one of those was an expert in infant killings. The report said families should be treated with "sensitivity, discretion and respect" and all those involved, including police, doctors and social workers, should work on a "presumption of innocence".
The report was welcomed yesterday and there were calls for its immediate implementation.
Miss Cannings, 41, who was cleared on appeal of killing her babies, seven-week-old Jason, and Matthew, three months, said: "I think the recommendations are clear and I hope that this report will be actioned as from today and there will not be any more delays - because the more delays, the more trauma that families are going through." Joyce Epstein, director of the Foundation for the Study of Infant Deaths, said: "The investigation of sudden infant death in this country lacks thoroughness and consistency, and vital evidence is being lost. We fully support the recommendations and hope it proves to be a springboard for major change." Liz Atkins, spokesman for the NSPCC, said: "It is vital that these tragic incidents are properly investigated without stigmatising parents." A spokesman for the Department for Education and Skills, which has responsibility for children, said: "We welcome the report and will study it with interest. It will inform the future handling of these tragic events and the steps necessary to prevent potential miscarriages of justice, while protecting the interests and safety of children."

ASSOCIATION OF MIDWIVES OF NEWFOUNDLAND and LABRADOR
APPLICATION FOR MEMBERSHIP
2005

Name: _____
(Print) (Surname) (First Name)

All Qualifications: _____

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_____

Postal code: _____ Telephone No. _____
(home)

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E-mail Address: _____

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Area where working: _____

Retired: _____ Student: _____ Unemployed: _____

List of Organizations of which you are a member (the Association receives requests from various organizations for representatives to review articles, attend conferences, be on committees). Your name would not be forwarded without your consent.

Provincial: _____

National:_____

International: _____

Would be interested in participating in a research project if asked: Yes ____ No _____

I agree to my address, postal and Internet, to be released to CAM: Yes ____ No _____

If already pay CAM fees as a **Full** member of another Canadian Midwives Association, name of Association:

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I wish to be a member of the Midwives Association and I enclose a cheque/money order from the post office

for: $_____
(Cheques/money orders only (no cash) made payable to the Association of Midwives of Newfoundland and Labrador).
Full membership for **ALL** midwives is **$75.00** (as this includes the Canadian Association of Midwives fees which the Association has to pay).
Associate membership for those who are <u>not</u> midwives is **$40.00**
Membership for those who are unemployed/retired is **$20.00**
Membership for those who are residing <u>outside of Canada</u> **$85.00** (to cover the cost of the extra postage).

Signed: _____ Date: _____

Return to: Pamela Browne, Treasurer, Box 1028, Stn. C, HVGB, Labrador, NL, A0P 1C0